FIAPAC

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Abstractbook

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Plenary sessions

PL 1

The history, the narrative and the language of contragestion

Elena Caruso

What is contragestion? Is it really a 'new' approach to fertility control? What lessons can we draw from its largely overlooked history? This presentation challenges the notion of contragestion as a novel and innovative concept by tracing more than seven decades of its neglected history. Based on little-known archival documents and a small set of new oral histories, it examines how the term has been variously coined, defined, adopted, and at times rejected across different contexts, while consistently retaining an elusive and contested meaning. Contragestion has been used at different times as a synonym for early medical abortion and emergency contraception, and as an umbrella term encompassing a range of fertility-control methods that operate within the little-known interval in-between emergency contraception and abortion. The presentation argues that this conceptual ambiguity may help explain why contragestion has not been very successful in the past, yet it suggests this ambiguity may be the key for its future relevance and potential success.

Drugs and Indications

Kristina Gemzell-Danielsson

Contragestion
The development of new contraceptive strategies has the potential to expand reproductive autonomy by offering women greater choice in when and how contraception is used. Beyond conventional daily or long-acting methods, emerging approaches include pericoital contraception, improved emergency contraception, intermittent dosing such as once-weekly or once-monthly regimens, and methods that may provide additional non-contraceptive health benefits.
Progesterone receptor modulators (PRMs), particularly mifepristone, provide an important model for exploring these possibilities because of their effects on ovulation, endometrial development and reproductive tract function. Depending on dose, timing and formulation, PRMs have been investigated for post-coital contraception, regular intermittent contraception, emergency contraception and very early medical abortion. Their effects on endometrial receptivity have also led to the concept of "contragestion", an approach aimed at preventing or interrupting the establishment of pregnancy at a very early stage.
This presentation will explore the concept of contragestion and its potential place between conventional contraception and early medical abortion. It will review the evidence for mifepristone and other PRMs across different dosing strategies, including pericoital, emergency, weekly and monthly use, as well as the potential clinical benefits and limitations of these approaches. The possibility of very early medical abortion before an intrauterine pregnancy is visible by ultrasound will also be considered.
Contragestion represents not simply a new method, but a broader woman-centred approach to reproductive health in which timing, flexibility, safety and individual autonomy are central. Further research into suitable agents, doses and delivery systems may help

determine whether contragestive methods can become a safe, acceptable and meaningful addition to the range of reproductive options.

Advocacy and service provision

Fatoumata Bah

Period pills are medications used to treat a delayed period without confirming pregnancy. Currently available across all 50 states in the US, primarily through telehealth, they offer an example of contragestion in practice. This presentation outlines lessons learned from existing period pills programs, ranging from asynchronous telehealth providers to small independent clinics. It examines how and why these programs were established, the clinical regimen used, and the terminology and communication approaches adopted to explain the method to clients. It considers the service-delivery models through which period pills are offered, as well as trends in client demand over time. It also examines key regulatory and legal considerations, including the challenges that arise when a method falls outside conventional contraception or abortion frameworks. Ultimately, this presentation aims to equip participants with a foundational understanding of period pills and prompt reflection on their relevance to contragestion programs in their own contexts.

PL 2

The changing landscape of inequitable access: abortion in the era of telemedicine

Rebecca Blaylock

Telemedical abortion has presented new opportunities for care which could not be fully realised within the clinic walls. Existing evidence demonstrates that telemedicine and home-use of both abortion medications (mifepristone and misoprostol) are safe, acceptable to most patients, and have removed barriers to care. However, we do not know whether patients across different socioeconomic groups and geographies have experienced these improvements equally.
In this talk I will share findings from a quasi-experimental study of 1.5 million abortions in England and Wales that provide robust evidence that the introduction of the home-use of mifepristone and associated telemedical models of care have increased the accessibility of abortion at a population level. Our findings show that home-use of mifepristone has improved some inequities of access (ethnicity), whilst others have persisted (age and deprivation), and new inequities have been introduced (type of abortion provider).
I will also draw on qualitative research with abortion patients to shed light on how some inequalities of access continue to be felt, and surface how preferences for care in the 'era of telemedicine' are shaped by patients' experiences and identities. Finally, I will ask us to expand how we think about 'access' and 'accessibility' in the context of abortion care.

Who Still Has to Travel? Rural–Urban Divides, Cross-Border Journeys, and International Routes to Care

Silvia De Zordo

Silvia De Zordo (PhD), social anthropologist, Associate Professor at the University of Barcelona. My research interests encompass reproductive governance, abortion, and social/gender inequalities in Latin America and Europe.
My doctoral dissertation (2008) examined the impact of family planning policies on the reproductive and contraceptive behaviour of working class, black women in Bahia (Brazil). As an Ellertson Fellow at Columbia University-Mailman School of Public Health-Dept. of Population and Family Health (2008-2010), I investigated health professionals' moral and religious convictions and their perceptions of legal and illegal abortion in Brazil, more specifically in Salvador da Bahia. I then continued to investigate this topic in Europe thanks to a Marie Curie Postdoctoral Grant at Goldmiths-University of London, and a Beatriu de Pinós Postdoctoral Grant at University of Barcelona.
In the last 4 years, I have been the Principal Investigator on a research project funded by the Spanish Ministry of Science and Innovation on abortion related mobilities and self-managed abortion in Europe and Latin America (REPROMOB - PID2020-112692RB-C22 - https://afin-barcelona-uab.eu/en/projects/repromob/repromob-subproject-2/). From 2016 to 2022 I led a European Research Council-funded project (Stg 680004) on barriers to legal abortion and abortion travel in Europe: https://europeabortionaccessproject.org/.

My publications include the volumes Reproduction and Biopolitics: Ethnographies of Governance, "Irrationality" and Resistance (ed. with Milena Marchesi), published by Routledge in 2014, which was awarded the CAR (Council on Anthropology and Reproduction) year's Most Notable Recent Collection in Anthropology and Reproduction Book Award, and A Fragmented Landscape: Abortion Governance and Protest Logics in Europe (ed. with Joanna Mishtal and Lorena Anton), published by Berghahn Books in 2016.
I also co-edited two Special Issues: "Re-situating Abortion: Bio-politics, Global Health and Rights in Neo-liberal Times", co-edited with Maya Unnithan and published in 2018 in Global Public Health, and " Demographic anxiety in the age of 'fertility' decline", co-edited with Diana Marre and Marcin Smietana and published in 2022 in Medical Anthropology. You can find more information about me and my publications here: https://orcid.org/0000-0002-8956-6566

Why so few providers? Skills gaps, training barriers, and the global shortage of 2nd– and 3rd-trimester surgical abortion care

Patricia Lohr

Dilatation and evacuation (D&E) is a safe, effective, and recommended method of later abortion, yet access remains uneven and trained providers are scarce in many settings. Drawing on global evidence, this presentation will examine how limited training and mentorship opportunities, institutional and service constraints, legal restrictions and stigma contribute to provider shortages. It will consider how service availability itself may shape opportunities to acquire and maintain D&E skills, and what is needed to develop sustainable pathways for training and provision that support patient choice.

PL 3

Trends in contraceptive use in the Nordic countries

Frida Gyllenberg

Has contraceptive use shifted over the past decades in the Nordic countries? This presentation focuses on what register studies and repeated survey studies tell us about trends in contraceptive use and factors that may affect these trends.

The role of social media in contraceptive decision-making

Montse Vallet Buisan

Social media has become an increasingly important source for contraceptive information, particularly among younger users. Unlike traditional health information channels, social media platforms emphasise personal testimony and discussion between users, thus creating an environment in which lived experience may carry similar or greater weight than clinical evidence. This presentation will examine how social media may influence contraceptive decision-making through three interconnected mechanisms: (i) increased visibility of individual experiences, (ii) amplification of negative or emotionally compelling narratives, and (iii) changes in trust towards healthcare professionals and medical institutions. Particular attention will be given to online narratives surrounding hormonal contraception, including accounts of adverse effects and contraceptive discontinuation, as well as the growing popularity of concepts such as “hormone balancing”, cycle tracking, and “natural” contraceptive approaches. These narratives should not, however, be dismissed simply as misinformation. Many reflect genuine adverse experiences, voice concerns that may have been insufficiently addressed in clinical encounters, or seek a space for validation and peer support. The difficult arises when individual experiences are presented as broadly generalisable; when particular narratives are repeatedly shared and promoted by social media platforms, they may appear more common than they are and influence perceptions of contraceptive risk. Contraceptive counselling therefore needs to engage with the experiences and concerns that people encounter online, while helping users place them within the wider clinical evidence.

What's behind changing attitudes towards hormonal contraception? Evidence from Austria

Christian Fiala

Abstract is not included, because this talk is part of a panel session.

What's behind changing attitudes towards hormonal contraception? Insights from a scoping review of global qualitative research

Nicola Boydell

Abstract is not included, because this talk is part of a panel session.

Panel Discussion

What rising abortion rates tell us about unmet contraceptive need

Teresa Bombas

Background: After decades of decline, abortion rates in several European countries have recently begun to rise again, despite long-term declines in unintended pregnancy and abortion recorded across Europe from 1990 to 2019. In England and Wales, 277,970 abortions were recorded in 2023, an 11% increase over 2022 and a 50% rise over the past decade, linked by providers to barriers in contraceptive access rather than to changes in sexual behaviour. This talk examines what these increases reveal about Europe's persisting unmet contraceptive need.
Discussion: The 2026 Contraception Policy Atlas Europe (EPF, 47 countries) shows a highly unequal landscape: France (97.9%), the United Kingdom (95.8%) and Portugal (93.8%) lead, while Hungary (36.9%), Slovakia (32.2%) and Russia (37.8%) trail; only 21 countries cover contraceptives, including long-acting methods, in their national health system, and only 8 provide free emergency contraception. The companion 2025 Abortion Policies Atlas shows similar disparities, from 94.6% (Sweden) to 0% (Andorra), amid barriers such as waiting periods and conscientious objection. In England and Wales, financial pressures influenced the decision for 57% of women in 2024, alongside long waits for contraceptive appointments; a third of women having an abortion had already given birth twice, pointing to a postnatal contraception gap. These findings echo evidence that contraceptive use varies widely across Europe, from 73% in Poland to over 90% in parts of Italy, and that a previous induced abortion predicts later contraceptive uptake — abortion as a sentinel marker of unmet need.
Conclusion: Rising abortion rates in parts of Europe, set against an estimated 164 million women worldwide with unmet contraceptive need, point not to a failure of abortion policy but to a failure to guarantee universal, affordable and timely access to modern contraception. Strengthening contraceptive access is essential to reducing unintended pregnancy and the demand for abortion.

Abortion is not a failure, but part of the reproductive continuum

Clare Murphy

Falling use of hormonal contraception and rising abortion rates are frequently interpreted as evidence of failure: of contraceptive services and education, of efforts to counter misinformation, particularly on social media, and ultimately of women themselves. This presentation challenges that framing, arguing that women’s reproductive risk calculations are changing as the context in which decisions about sex, contraception, abortion and pregnancy has itself changed.
Rather than treating contraception use as success and abortion as failure, we should understand contraception, emergency contraception and abortion as interconnected forms of fertility regulation. For some women, accepting a risk of pregnancy, knowing that abortion is available if needed, may be a rational choice consistent with her own values. Recognising this reproductive continuum requires moving beyond contraceptive uptake as the overriding measure of success and towards reproductive healthcare that starts with a woman’s own circumstances, preferences and tolerance of risk.

PL 4

Managing First-Trimester Miscarriage: Results of the First Global Practice Survey

Christian Fiala

Background: "Miscarriage" conflates two physiologically distinct situations that require different management. In missed abortion, fetal development stops while the pregnancy continues hormonally: progesterone stays normal, and there is usually no bleeding and no urgency. In spontaneous abortion, the problem is on the side of the pregnant woman, a corpus luteum insufficiency lowers progesterone, triggering cervical opening, contractions and bleeding, while the fetus may still be viable. This distinction is decisive. Missed abortion requires progesterone blockade with mifepristone, as in medical abortion, followed by misoprostol 1–2 days later once the myometrium is sensitized and the cervix opened. Spontaneous abortion, where progesterone has already fallen, needs no mifepristone: treatment with misoprostol alone should be given immediately to complete expulsion.
Aims: To describe how miscarriage is managed in practice, and how HCPs differentiate the two situations and adapt treatment.
Methods: Worldwide survey of 713 HCPs, mostly obstetrician-gynaecologists.
Results: Diagnosis relied on vaginal ultrasound (near-universal; 31% abdominal) and hCG (75%). Combined mifepristone plus misoprostol was used for missed abortion by 67%, where it is evidence-based, but also by 42% for spontaneous abortion, where misoprostol alone is indicated. Misoprostol alone was given appropriately in 67% of spontaneous abortions, yet half of HCPs also used it for missed abortion, despite its insufficiency when progesterone is high. Typical dosing was 800 mcg misoprostol vaginally, or 200 mg mifepristone plus 800 mcg misoprostol. Repeat misoprostol was common in the misoprostol-alone regimen (91%) but less so when combined (54%). Home administration was standard for 80%. Concerning treatment options, women's preference was the main decision factor in 90%.
Conclusions: Practice frequently diverges from the evidence, reflecting confusion between two fundamentally different conditions that share one term. HCP requested clearer guidelines (56%) as the main aspect in improving treatment. This should begin by distinguishing missed from spontaneous abortion.

Pain management for medical abortion

John Reynolds-Wright

Invited presentation: Clinical Update on Pain relief during medical abortion.
Overview of evidence for managing pain during medical abortion at different gestations and in different settings.
Discussion of how to develop a tool to help clinicians and patients manage pain during medical abortion, particularly at home. In collaboration with Dr Carrie Purcell, Open University, United Kingdom.

Abortion beyond 1st trimester

Guillermo Ortiz

Abortions at or after 13 weeks' gestation represent a minority of abortions worldwide but contribute disproportionately to serious abortion-related complications even death, particularly where timely, safe care is restricted. People seeking care at these gestations are more likely to be young, experience delayed pregnancy recognition, face violence, uncertainty, financial or logistical barriers, or have maternal or fetal indications identified later in pregnancy. This lecture summarizes evidence-based clinical approaches to abortion care after 13 weeks, including medical abortion with mifepristone and misoprostol or misoprostol alone, and dilatation and evacuation (D&E). Both methods are safe and effective, although they differ in duration, predictability, resource requirements, and adverse-event profiles; when clinically appropriate and available, individuals should be offered an informed choice.
Also reviews indications, acceptability, and commonly used regimens for inducing fetal asystole, noting that routine preprocedural fetal demise does not improve abortion safety but may be considered for legal, facility, social, or patient-centered reasons. Additional guidance addresses prolonged induction, retained placenta, uterine scars, placenta previa and accreta risk, cervical preparation, tissue evacuation, and management of potential complications.
Overall, high-quality care after 13 weeks requires evidence-based protocols, trained providers, appropriate referral and emergency capacity, respect for autonomy, and individualized clinical decision-making.

PL 5

Quieroabortar.org: A State-level Initiative to Monitor and Advance Equitable Access to Abortion Care Across Spain

Silvia Aldevert & Jordi Baroja

"QuieroAbortar is a pioneering programme in Spain developed by a civil society organisation of healthcare professionals and born from a simple but critical finding: having a legal right to abortion does not necessarily mean knowing how, where or under what conditions to access it. Conceived from the intersection of healthcare practice and activism, the programme initially responded to widespread gaps in reliable, accessible and territory-specific information on abortion pathways across Spain. Since then, QuieroAbortar has evolved into an interconnected ecosystem combining an updated nationwide website, individual counselling through WhatsApp, an abortion support hotline inspired by international experiences such as Abortion Talk, and specialised accompaniment for people seeking abortion beyond 22 weeks of pregnancy. Rather than operating as separate services, these different entry points allow the programme to identify barriers, inequalities and emerging needs directly from the experiences of abortion seekers.
But QuieroAbortar goes beyond providing information and individual support. The knowledge generated through these encounters is systematically transformed into evidence for advocacy, including reports and proposals for changes in Spanish abortion policies and legislation. At the same time, the programme works with healthcare professionals through training, peer support and spaces for reflection aimed at addressing abortion stigma and strengthening professional engagement in abortion care. In only a few years, QuieroAbortar

has become a reference point by bringing together four dimensions that are too often addressed separately: information, accompaniment, knowledge and advocacy, and professional support. This presentation will explore how integrating these dimensions creates a distinctive model of healthcare activism: one in which civil society and healthcare professionals can simultaneously respond to individual needs, identify structural barriers and use practice-based knowledge to transform abortion access."

Access to Abortion in the Southern mediterranean: Challenges and Opportunities

Selma Hasjri

In the MENA region, nearly 80% of women live in countries where abortion is heavily restricted. More specifically, 55% of them reside in states where pregnancy termination is only authorized to save the mother's life, and 24% in countries where it is only permitted to preserve her physical or mental health. This situation makes the MENA region the only one in the world where no significant legislative evolution has occurred since independence, with the exception of Tunisia (1973) and Turkey (1981). Recent attempts to broaden the indications in Morocco (2015) and Algeria (2017) have also failed.
According to reports from the United Nations Population Fund (UNFPA), approximately one in ten pregnancies in the Muslim-majority countries of the region ends in abortion. For the North Africa sub-region, historical estimates indicate a rate of approximately 38 abortions per 1,000 women of reproductive age (Guttmacher Institute).
Although Muslim religious authorities generally consider that abortion interferes with the will of Allah, the sole holder of the right to life and death, the five major branches of Islam present nuanced positions, some being less dogmatic than others. However, this legislative rigidity is mainly explained by a deeply rooted patriarchal domination and by the refusal to recognize women's sexual desire as independent from male decision-making (father, brother, husband, or even son).

Abortion Access and Barriers in Central and Eastern Europe

Cristian Furau & Ana Mitrovic

Abortion is legally available on request or on broad grounds in much of Central and South-Eastern Europe, yet legal entitlement does not necessarily translate into timely, affordable and equitable access to care. This presentation examines the gap between formal abortion policy and real-world service provision in selected countries of the region, with a particular focus on Romania, Hungary, Serbia, Bulgaria, Albania and Montenegro.

Using a comparative review of current legal and policy frameworks, service-delivery models, international guidance and available regional evidence, we explore how access is shaped not only by legislation but also by the organisation and resilience of health systems. Across the region, country-specific combinations of provider shortages, conscientious objection or refusal of care, geographical concentration of services, out-of-pocket costs, mandatory administrative requirements, limited availability of medical abortion, insufficient public information and persistent abortion-related stigma may create substantial barriers, particularly for adolescents, people living in rural or socioeconomically disadvantaged settings, and those seeking care later in pregnancy.

The analysis highlights an important regional paradox: abortion may be legally permitted while remaining practically difficult to obtain. In this context, expanding evidence-based medical abortion, appropriate task-sharing, decentralised service provision, telemedicine and supported self-management could reduce dependence on a limited number of facility-based providers and improve continuity of care. These approaches should, however, be embedded within health systems that ensure reliable information, quality medicines, clinical support when needed and accessible referral pathways.
Moving from legal availability to effective accessibility requires systematic monitoring of abortion services, protection of continuity of care, removal of medically unnecessary barriers and greater alignment of national policies with current WHO recommendations. A regional approach based on measurable access rather than legislation alone may provide a more meaningful framework for improving equitable, person-centred abortion care across Central and Eastern Europe.

PL 6

Panel discussion about Abortion Access & Advocacy in the world, and Contragestion Across

Sheila Akinyi

Across Africa, access to safe abortion remains shaped by intersecting legal, policy, health-system, socio-cultural and logistical barriers. Restrictive and inconsistently interpreted legal frameworks, abortion stigma, provider attitudes, misinformation, uneven availability of quality-assured commodities, cost and geographical barriers continue to create a significant gap between evidence, policy and people's ability to access timely, confidential and respectful abortion care.
The African Coalition for Research and Communication on Abortion (ACORCA) brings together African research institutions and partners to strengthen the generation, communication and use of abortion research across the continent. ACORCA works to advance African-led abortion research and research capacity, identify and respond to evidence priorities, and strengthen the translation and communication of research to inform policy, programmes, advocacy and public discourse. Drawing on ACORCA's work and wider experience across abortion service delivery, movement building and community-led access, this presentation examines what is required to bridge the gap between evidence and people's lived realities.
A key lesson is that evidence alone does not create access. Research and policy must connect with the practical realities of how people seek information, navigate stigma and health systems, obtain quality-assured commodities and reach appropriate care. Experiences from **NAWIRI's Senje Hotline in Kenya**, a community-led model combining digital and social media advocacy, trusted influencers, confidential and non-judgmental information and support, licensed pharmaceutical supply channels, and values-clarified last-mile delivery networks, illustrate how some of these barriers can be addressed in practice.
These experiences also reveal reproductive needs that do not always fit neatly within conventional distinctions between contraception and abortion, including women seeking options after missing emergency contraception but before pregnancy confirmation. Such practice-based insights raise important questions for research and reinforce the need for African-generated evidence that reflects how women actually experience and navigate reproductive decision-making.

The presentation argues for an ecosystem approach to abortion access—connecting African-led research and evidence translation with advocacy, community knowledge, quality service delivery and lived experience. Strengthening this continuum is critical to ensuring that abortion research does not end with publication but contributes to policies, programmes and practices that meaningfully expand reproductive autonomy and access across Africa.

Nandini Mazumder

No abstract was received

Agustina Michel

No abstract was received

Sadok Amine Ben Hassine

No abstract was received

Lunch Session

Very early medical abortion (VEMA)

Teresa Bombas

Very early medical abortion (VEMA) refers to abortion with mifepristone and misoprostol started before an intrauterine pregnancy (IUP) is visualized on ultrasound, now possible given high-sensitivity urine B- hCG tests that confirm pregnancy at very early gestational ages. Definitions and practice vary widely between countries, and many providers delay treatment until IUP is confirmed, mainly for fear of missing an ectopic pregnancy. This presentation reviews international survey data on provider practice, a systematic review of medical abortion before confirmed IUP, a multicenter randomized non-inferiority trial comparing immediate versus delayed treatment, and a prospective cohort study of VEMA outcomes. Evidence shows ectopic pregnancy is rare and, with adequate follow-up, is diagnosed as early with immediate as with delayed treatment. Complete abortion rates are high, with only a slightly higher rate of ongoing pregnancy. VEMA appears safe, effective and acceptable, minimizing women's distress, visits, bleeding and pain, and supports a shift toward immediate treatment on request.

Implementing VEMA in Daily Practice

Sharon Cameron

No abstract was received

Free Communications

FC 1

First year experiences without routine pre-abortion ultrasonography from a Nordic tertiary clinic: a comparative cohort study

Dr Maarit Mentula[1], Med Student Sonja Nordman[2], Prof Oskari Heikinheimo[1], Dr Janina Kaislasuo[1]
[1]Helsinki University and Helsinki University Hospital, Helsinki, Finland. [2]Helsinki University, Helsinki, Finland

Background:
The Finnish national guideline on abortion care was updated in 2024 enabling the use of an interview-based no-test model developed by the RCOG. Here we present our first-year results from the largest Finnish abortion service, the Helsinki University Hospital.

Objectives:
The aim of this study was to compare the safety and efficacy of an interview-only, no-test approach to traditional care including routine pre-abortion ultrasonography in a setting where abortion is both widely accepted and accessible at low cost via public health care.

Methods:
This retrospective cohort study compares two cohorts of women, 1439 in total, requesting first trimester medial abortion but treated using different protocols. The ultrasonography cohort (n=699) represents an unselected patient population requesting medical abortion between January 1st and April 30th, 2024, while the no-test cohort (n=740) represents women qualifying for no-test abortion based on the RCOG decision aid after a phone-interview and a subsequent in-person nurses appointment and treated without invasive tests between February 24th and December 31st, 2025. Data from electronic medical records were used to compare outcomes between cohorts.

Results:
Patients treated with the no-test approach received care earlier (mean [SD] gestational age 44[8] days vs 53[14], p<0.001). The no-test approach outperformed routine ultrasonography, showing a higher rate of complete abortion (95.0% vs. 88.8%, p<0.001) and less complications (5.0% vs. 11.2%, p<0.001). The rate of serious adverse events, including extrauterine pregnancy and need for emergency surgery, did not differ between the cohorts (0.7% vs 0.4%, p=0.53). Ongoing pregnancies were more common in the no-test cohort (1.4% vs 0.3%, p=0.03).

Conclusions:
The interview-based no-test approach was safe and effective compared to using routine ultrasonography. By removing the barrier of routine ultrasonography requirement women received care earlier. Both favorable outcomes and somewhat higher rates of ongoing pregnancy are explained by early treatment.

FC 2

30 mg compared with 60 mg of ulipristal acetate prior to misoprostol for early medication abortion: a double-blind, placebo-controlled randomized trial

Beverly Winikoff[1], Manuel Bousiéguez[2]
[1]Gynuity Health Projects, New York City, USA. [2]Gynuity Health Projects, Mexico City, Mexico

Background:
Medication abortion using mifepristone and misoprostol is safe and effective. Yet, multiple factors limit access to mifepristone. Identifying effective alternatives to mifepristone is essential for expanding access to safe medication abortion. Ulipristal acetate, with a similar chemical profile, presents a promising alternative.

Objectives:
To evaluate whether a single 30mg dose of ulipristal acetate maintains comparable efficacy, safety, and acceptability to a single 60mg dose when used in combination with misoprostol for medication abortion through 63 days of gestation.

Method:
Gynuity Health Projects is conducting a clinical trial to compare 30mg vs 60mg ulipristal acetate taken orally in-clinic, followed by misoprostol 800mcg taken buccally 24 hours later at home. The study is enrolling participants (n=426) at two public hospitals in Mexico City and determining gestational age and abortion status with ultrasound. For participants who do not attend a follow-up visit, self-reported outcomes are used to assess abortion resolution. Primary outcome is complete abortion without need for additional intervention. Secondary outcomes include incidence of side-effects and complications, and acceptability of the two regimens.

Results:
In a previous proof-of-concept study, a regimen of 60mg ulipristal acetate plus 800mcg misoprostol resulted in complete abortion in 129/133 participants (97%), with no serious adverse events and high satisfaction and acceptability. These findings supported further investigation to evaluate dose optimization in a randomized setting. Enrollment in the current trial is ongoing and expected to be completed in advance of the conference; results will be available at the time of presentation.

Conclusions:
The study addresses a critical evidence gap regarding optimal dosing of ulipristal acetate for medication abortion while strengthening evidence on the efficacy of the 60mg dose in a larger, controlled population. Demonstrating comparable efficacy at a lower dose could reduce cost, expand availability, and support broader implementation of medication abortion regimens involving ulipristal acetate.

FC 3

Correctional officer role in prisoner access to abortion and contraception: a qualitative study

Clare Heggie, Anja McLeod, Dr. Martha Paynter
University of New Brunswick, Fredericton, Canada

Background:
Correctional officers (CO) play a significant but often unacknowledged role in access to health services for incarcerated women, including access to abortion and contraception. Though occupying non-clinical positions, COs field healthcare requests and questions, monitor incarcerated people's health, and escort people to external appointments. Despite this involvement, there is little research on their experiences, training, or resource needs.

Objectives:
To understand the experiences of COs working in provincial jails for women in Canada with respect to abortion and contraception care.
Methods: We recruited COs through partnerships with three provincial jails for women in Canada. We conducted interviews in person. We analyzed data using reflexive thematic analysis.

Results:
COs described performing a diverse range of roles in the prison, including occasionally performing clinical tasks such as a medication dispensation. This diversity of scope led to COs feeling conflicted between providing support and their main duty to security. This conflict was particularly acute during escort to external abortion care appointments, where COs felt they were expected to provide emotional support while also restraining and surveilling prisoners. COs found reproductive health to be a ubiquitous concern, intersecting with other needs related to substance use and mental health. Finally, COs identified training needs related to provincial abortion policies, contraception options and public drug coverage, and how to discuss abortion with clients in an affirming way while protecting privacy and confidentiality.

Implications:
As the staff with the most daily contact with incarcerated women, COs play a significant role in facilitating access to abortion and contraception in prisons. Equipping COs with evidence-based and appropriate information within their scope as non-clinical staff could help remove access barriers for incarcerated women. In response, we developed three training modules to be delivered in-person to COs. Modules are currently being piloted and evaluated at two provincial jails for women.

FC 4

Abortion care barriers, experiences, and preferences among transgender, gender diverse, and intersex people

Dr. Heidi Moseson[1], Mx. Sachiko Ragosta[1], Mx. Sydney Reese[1], Ms. Katherine Key[1], Ms. Morgan York[1], Mx. Alex Torrez[2], Dr. Jen Hastings[3], Mx. Bex Groth[4], Dr. Mitchell R. Lunn[5,6], Dr. Annesa Flentje[5,6], Dr. Juno Obedin-Maliver[5,6]

[1]Ibis Reproductive Health, Oakland, USA. [2]UC Berkeley, Berkeley, USA. [3]Gender Care Clinic, Santa Cruz, USA. [4]University of Georgia, Athens, USA. [5]Stanford University, Stanford, USA. [6]The PRIDE Study, Stanford, USA

Background:
Transgender, gender diverse, and intersex (TGDI) people have abortions, yet the experiences, preferences, and barriers they face accessing abortion care remain overlooked in abortion research and care worldwide.
Objectives: To describe barriers, experiences, and preferences for abortion care among TGDI people for the purpose of working towards more inclusive abortion care for these underserved populations.

Methods:
From August 2025–January 2026, we recruited TGDI participants from The PRIDE Study — a national longitudinal cohort of LGBTQIA+ people's health — to complete an online sexual and reproductive health survey with measures covering abortion history, access barriers, and care preferences. The analytic sample comprised U.S.-resident, English-literate TGDI adults (≥18 years) born with a uterus (n=1,168).

Results:
Thirteen percent of respondents reported ever being pregnant; of these, 30% reported a lifetime abortion and ~4% since the 2022 SCOTUS Dobbs ruling. Seven percent were unable to obtain a wanted abortion. Nearly one-quarter had considered self-managed abortion (SMA) and 10% had attempted it — 47% of whom used mifepristone and misoprostol, 13% used emergency contraception, and 7% used misoprostol-only. Nearly all attempts (93%) also involved some form of physical trauma - hitting oneself in the stomach, inserting an object into the body, or falling down stairs. The most prevalent barrier to abortion was cost (47%); additionally, 15% reported discrimination concerns. For a future abortion, respondents preferred self-managed medication abortion (MAB) (22%), facility-based procedural abortion (22%), facility-based MAB (17%), and telehealth MAB (16%).

Conclusions:
TGDI individuals face unique and compounding barriers to abortion care, and express diverse care model preferences that balance method autonomy and effectiveness. Given a preference for SMA, yet use of unsafe methods, public health communication is needed to raise awareness of and support for safe and effective methods of SMA for TGDI people. Results encourage abortion providers to better center TGDI patients' needs and preferences.

FC 5

Who seeks abortion care support and where do they go? A 6 Month Service Evaluation of Cross-Border Abortion Support Across Europe

Chloe Hanse, Lucy Wilkinson, Ciara McHugh
Abortion Support Network, London, United Kingdom

Background:
Restrictive abortion legislation across Europe forces many people to seek care across national borders. Abortion Support Network (ASN) provides practical support (funding, accommodation, and referrals) to people unable to access abortion care in their country of residence.

Objectives:
To describe the demographic profile, vulnerability characteristics, gestation at presentation, and referral destinations of people contacting ASN over a six-month period.
Methods: We analysed 578 anonymised closed cases opened between October 2025 and March 2026 from ASN's case management system. Variables analysed included country of residence, age, gestation, vulnerability markers, referring country, foetal anomaly status, and financial assistance requirement.

Results:
Cases spanned 31 countries. Poland (22%,n=128) and Ireland (22%,n=126) together accounted for 43%(n=254) of cases, followed by France (10%,n=59), England (9%,n=53), and Germany(7%,n=37). Mean age was 29.4 years; 25.3%(n=146) were 24 or younger. Overall, 62%(n=360) presented at 13 weeks gestation or later, with a mean gestation of 15.4 weeks. Among foetal anomaly cases (n=34), mean gestation was 22.4 weeks. Financial assistance was provided to 22%(n=127) of abortion seekers. 15% (n=88) had a safeguarding concern flagged. Vulnerability markers included migrant status (28%, n=25), mental health conditions (25%, n=23), age under 25 (25%,n=22), domestic abuse (19%, n=17), homelessness (14%,n=12), and sexual violence (6%,n=5), with frequent co-occurrence. Of the 205 referred cases, 49%(n=101) were referred to the Netherlands, 36.6%(n=75) to the UK, with the remainder to Belgium (6%, n=12), Spain (5%,n=11) and Mexico (2%,n=4).

Conclusion:
People contacting ASN include some of the most marginalised individuals affected by restrictive or inadequate abortion provision in Europe. Cross-border travel is not a neutral alternative to domestic access. These findings highlight the essential and underrecognised role of civil society in European abortion care infrastructure, and the urgent need for policy responses that address structural inequity.

FC 6

Preparing future doctors for abortion-related care: a national Freedom of Information (FOI) study of UK medical school teaching

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Background:
Abortion is a common and essential part of healthcare and “Termination of pregnancy” is listed in the General Medical Council’s *Medical Licensing Assessment* content map as core knowledge for UK practice, yet there is limited evidence on how it is taught in UK undergraduate medical education.

Objectives:
We aimed to evaluate the extent and content of abortion teaching in UK medical schools.

Methods:
Freedom of Information requests were sent to the 42 established UK medical schools in 2025–2026. Schools were asked whether abortion teaching was provided, which year(s) it was delivered, teaching format, hours allocated to legal/ethical, clinical, communication and conscientious objection content, assessment methods and availability of clinical placements.

Results:
41 medical schools responded (98%). 40 reported providing some abortion teaching. Teaching most commonly took place through lectures and small-group sessions during obstetrics and gynaecology teaching. Most schools reported providing at least 2 hours of teaching on legal/ethical and clinical aspects of abortion, while communication skills and conscientious objection received less curricular time and were frequently absent or unspecified. 32 medical schools formally assessed abortion care; assessment methods varied and included written examinations and OSCEs (Objective Structured Clinical Examinations). Only 11 schools reported offering clinical placements or direct exposure to abortion care; 25 reported that no placements were available.

Conclusions:
Undergraduate abortion education is provided in most responding UK medical schools but is variable in content, duration and clinical exposure. Teaching is weighted towards legal and ethical aspects of abortion, with less emphasis on communication skills and preparing students to provide abortion-related care. Limited access to clinical placements may contribute to ongoing stigma and workforce shortages in abortion services. National guidance on abortion education and improved access to clinical learning opportunities are needed to support a competent and confident future workforce.

FC 7

Digital contraceptive counseling at the time of emergency contraception purchase in pharmacies and uptake of effective contraception: a pragmatic cluster-randomized crossover trial

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Background:
Emergency contraceptive pills (ECPs) are widely available over the counter in Swedish pharmacies, but provision does not include contraceptive counseling. As ECPs postpone ovulation, subsequent unprotected intercourse increases unintended pregnancy risk. Rapid initiation of effective contraception after ECP use is therefore recommended. Current practices leave the majority of ECP users without follow-up contraceptive care.

Objectives:
To evaluate whether digital contraceptive counseling at the time of ECP purchase increases uptake of effective contraception at 1-month follow-up.

Methods:
This pragmatic cluster-randomized crossover trial included 37 pharmacies in the Stockholm region and 599 women purchasing ECPs in 2024–2025. Participants in intervention pharmacies received digital contraceptive counseling via their smartphones, along with facilitated access to contraceptive services, while controls received standard care. Outcomes were assessed through online questionnaires and analyzed using mixed-effects logistic regression models accounting for clustering by pharmacy.

Results:
Follow-up data at one month were available for 496 participants (82.8%; median age 27 years), of whom 85% had not used effective contraception in the past month. In the intention-to-treat analysis, there was a non-significant increase in effective contraceptive use: 28.0% in the intervention group and 21.5% in the control group (adjusted OR 1.31, 95% CI 0.78–2.20, p=0.307).
A significant interaction was observed between study arm and recent use of effective contraception (p=0.011). Among participants who had not used effective contraception in the past month, the intervention significantly increased uptake (20.5% vs 11.9%; adjusted OR 1.87, 95% CI 1.01–3.47; p=0.047). No benefit was observed among those with recent use.

Conclusions:
Digital contraceptive counseling at the time of over-the-counter ECP purchase in pharmacies increases uptake of effective contraception among women with no recent use of such methods. Delivered without requiring pharmacy staff involvement, this intervention represents a scalable strategy to reduce unmet contraceptive need and potentially prevent unintended pregnancies.

FC 8

Identifying the top 10 research priorities for abortion care

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Background:
Despite its importance to public health, abortion remains an under-researched area and research priorities have not previously been systematically identified. The James Lind Alliance (JLA) Priority Setting Partnership (PSPs) methodology brings together people with lived experience, carers and clinicians to identify and prioritise the most important unanswered questions within a health topic. There is currently no PSP on abortion care.

Objectives: The purpose of this PSP is to identify the top 10 most important unanswered questions about abortion care in the UK from the perspectives of people with lived experience of abortion, their supporters, and healthcare professionals providing abortion care so that future research better reflects shared priorities.

Methods:
The JLA uses an established and transparent methodology to develop PSPs. Evidence uncertainties were collected through an online survey of people with lived experience, supporters and abortion care providers. Submitted questions will be themed and refined into summary questions. A second survey and final consensus workshop will prioritise these questions to generate the top 10 research priorities for abortion care in the UK.

Results:
The survey received 770 questions from 240 respondents. Our interim analysis highlighted key potential research themes across different groups. These include access to abortion care and reducing inequities across underserved groups and different UK regions/nations;

abortion stigma; information provision and counselling; emotional support and aftercare; patient experience across the pathway; and pain management.

Conclusions:
This PSP will be the first nationally agreed research agenda for abortion care in the UK, with the findings also being applicable to other countries. By integrating the perspectives of people with lived experience, their supporters and abortion providers, the resulting priorities will guide research funding, address evidence gaps and support improvements in abortion care delivery and patient experience.

FC 9

Results of an early-terminated phase III trial of once-weekly Mifepristone 50 mg as a contraceptive

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Background:
Mifepristone 50 mg acts as a progesterone receptor modulator and has an established role in emergency contraception. Its estrogen- and progestogen-free profile and weekly dosing regimen offered a promising alternative to existing hormonal contraceptives.

Objectives:
To evaluate the efficacy, safety, and acceptability of mifepristone 50 mg administered once weekly as a novel contraceptive method.

Methods:
A prospective, open-label, phase III multicentre study was conducted across 14 centres in the Netherlands. The planned enrolment was 1,186 regularly menstruating participants aged 18–45 years over 12 months (13 cycles of 28 days). Mifepristone 50 mg was self-administered orally once weekly. Each participant attended four scheduled study visits involving transvaginal ultrasound and blood sampling. Daily electronic diaries captured pill intake, at-home pregnancy test results, bleeding patterns, and adverse effects.

Results:
The trial was terminated early on 1 June 2026 due to the observed ectopic pregnancy rate, at which point 565 of the planned 1,186 participants had been enrolled. At the time of analysis, 2,960 analysed cycles, of which 2,554 cycles with perfect use (one tablet every seven days), were evaluated. Twenty positive pregnancy tests were recorded, of which three were ectopic pregnancies. Full efficacy and safety outcomes, together with analyses of possible underlying causes, will be presented at the conference.

Conclusions:
Once-weekly mifepristone appeared promising as a contraceptive based on previous studies. However, this larger and longer phase III trial shows that weekly administration of mifepristone 50 mg is unsuitable for further development as a general contraceptive method due to safety concerns observed in this study

Posters

After an abortion

P 1

Inadequacy between post-abortion care and immediate post-abortion contraception: 189 Versus 6 Cases at CHUMEFJE Libreville, Gabon

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Background:
Unsafe abortion complications remain a leading cause of maternal morbidity in Gabon. Post-Abortion Care PAC saves lives, but its impact depends on preventing recurrence through immediate post-abortion contraception. The adequacy between PAC and contraceptive provision is poorly documented.

Objective:
To assess the adequacy between PAC delivery and provision of immediate post-abortion contraception among women aged 15-45 admitted at CHUMEFJE.

Methods:
Retrospective descriptive single-center study. All patients aged 15-45 admitted for PAC at Jeanne Ebori Mother-Child University Hospital Center in Libreville from January 1st to December 31st 2022 were included. Primary outcome: proportion of women receiving contraception before discharge.

Results:
Of 189 PAC cases recorded in 2022, 100% received emergency treatment for complications. Only 6 patients, 3.2%, left the hospital with a contraceptive method. The 15-45 age range confirms high exposure to risk of repeated unintended pregnancy.

Conclusion:
This study reveals a major gap in the continuum of care at CHUMEFJE. Treating complications without systematic prevention creates a "revolving door". Mandatory integration of contraception into the PAC package, with 24h/24 kit availability and systematic counseling, is urgent to reduce maternal morbidity in Gabon, in line with the Maputo Protocol.

Conscientious Objection

P 2

Provider stigma and abortion stigma among women are bidirectionally reinforcing- evidence across low-middle-and-high-income countries

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Background:
Abortion stigma is not a monolithic phenomenon; it affects multiple actors in abortion-care ecosystem, most prominently healthcare providers and women seeking abortion services. Provider stigma contributes to discrimination, professional isolation, burnout, and reluctance to provide care. Stigma among women reveals shame, secrecy, fear of disclosure, and delayed care-seeking. Emerging evidence indicates interaction and may mutually reinforce one another, undermining safe-abortion access and quality reproductive healthcare.

Objectives:
To compare provider stigma and abortion stigma among women across low-(Pakistan, Uganda), middle-(Nigeria, India, Brazil, South Africa) and high-(United Kingdom, Canada) income countries, and to examine how their interactions influence access, provision, and outcome of abortion-care.

Methods:
Studies from selected countries were analyzed to identify common drivers, manifestations, and consequences of stigma, and to map interactions between providers and abortion clients with attention to structural determinants: legal restrictions, religious beliefs, and socio-cultural norms.

Results:
Provider stigma and abortion stigma among women were evident across contexts but with varied intensity and expressions. In low-income settings, restrictive laws, religious norms, and fear of legal repercussions increased provider reluctance and heightened women's fear of disclosure and deferred care-seeking, contributing to unsafe/self-managed abortions. In middle-income countries, legal availability did not remove barriers: provider judgment, institutional impediments, and misuse of conscientious objection limited access. In high-income countries, overall stigma was lower, yet marginalized populations continued to experience substantial barriers. Across settings, bidirectional relationship emerged: stigmatizing provider attitudes and obstructive practices increased women's fear, shame, and avoidance of services, while women's secrecy and delayed presentation reinforced providers' moralizing perceptions. Restrictive laws and social norms served as shared structural determinants.

Conclusions:
Abortion stigma among providers and women are distinct yet reciprocally reinforcing barriers. Sustainable improvements to protect/improve equitable access require integrated strategies: provider support and values-clarification, respectful client-centered care, and enabling legal and social-cultural environments.

Contraception

P 3

The Abstinence Paradox: adolescent contraception attitudes vs. pregnancy outcomes in FCT, Nigeria

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Introduction:
In Nigeria, cultural and religious norms often present abstinence as the only acceptable "contraception" for unmarried adolescents. Yet, high rates of unintended pregnancy and unsafe abortion suggest a profound disconnect between what young people say and what they do.

Objectives:
This study investigated attitudes toward contraception among adolescents aged 14–16 in three secondary schools around Nigeria's Federal Capital Territory (FCT) and explored teachers' explanations for the gap between contraceptive aversion and observed pregnancy outcomes.

Results:
A mixed-methods design was used. A structured survey measured attitudes toward contraception in 300 randomly selected students (150 female, 150 male; ages 14–16). Concurrently, semi-structured interviews were conducted with 12 teachers (4 per school) to provide qualitative insights. School health records on pregnancies and unsafe abortions were reviewed with permission. Of 300 students, 296 (98.7%) selected "Strongly Disagree" to "I would use contraception if I were sexually active." All 296 named "abstinence only" as their preferred method. Only 4 students (1.3%) indicated openness to condoms. No significant gender differences were found. Despite these attitudes, school records documented an average of 12–14 adolescent pregnancies per school in the past year, along with numerous unsafe abortions and one confirmed death in 2026 from abortion complications. Teacher interviews revealed three themes: (1) a "public abstinence, private sexuality" double life; (2) fear of stigma as the primary barrier to contraception; and (3) complete absence of youth-friendly, confidential SRH services.

Conclusion:
A dangerous "abstinence paradox" exists where adolescents publicly reject contraception while privately engaging in unprotected sex, resulting in preventable pregnancies and deaths. Abstinence-only messaging does not stop sexual activity—it stops contraceptive use. Interventions must provide confidential, non-judgmental contraceptive access and comprehensive sexuality education that bridges attitude and behavior. Findings directly address FIAPAC's theme of underserved populations (young people/adolescents) and the topic of contraception skepticism and public perceptions.

P 4

Measuring lactation initiation after early postpartum Injectable Progestin use among women in Nepal

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Introduction:
Short interpregnancy intervals are common globally and in Nepal and are linked to increased maternal and infant morbidity and mortality. Despite a high unmet need for postpartum contraception, uptake is often delayed due to concerns about effects on lactation. Depot medroxyprogesterone acetate (DMPA), the most widely used reversible contraceptive in Nepal, is effective, acceptable, and can be administered by nurses and community health workers. However, concerns that early postpartum progestin use may delay lactogenesis or impair infant growth have limited early initiation. Although existing evidence suggests progestins do not harm breastfeeding, high-quality data specific to DMPA remain limited.

Methods:
We conducted a prospective longitudinal pilot study among 42 women who initiated DMPA immediately postpartum at a public hospital in Nepal (March–April 2025). Participants had not yet experienced lactogenesis at enrollment. Lactogenesis was assessed daily during hospitalization and via follow-up phone calls after discharge. Weekly phone surveys (weeks 1–6) assessed breastfeeding and contraceptive use. An in-person survey at 12 weeks evaluated breastfeeding continuation, contraceptive use and satisfaction, and resumption of sexual activity. Outcomes were summarized using descriptive analyses.

Results:
Mean time to lactogenesis was 49.3 hours, with no cases of lactation failure. Exclusive breastfeeding was nearly universal: 100% through 4 weeks and 97.5% at 12 weeks. Seventy percent of participants received a second DMPA injection on time, and satisfaction was high. Some women discontinued contraception without switching methods despite wishing to avoid pregnancy. All participants resumed sexual activity by 12 weeks (mean 20 days).

Conclusions:
Immediate postpartum DMPA initiation was acceptable and did not adversely affect lactation. These findings support integrating early DMPA use into postpartum family planning services in Nepal. Improved counseling on continuation and method switching is needed, and larger randomized trials are warranted.

P 5

A systematic review of mifepristone as a non-emergency contraceptive

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Background:
Mifepristone may be an effective non-emergency contraceptive pill with several advantages over other hormonal contraceptive options.

Objectives:
To synthesize the available evidence, we have performed a systematic review and meta-analysis of the effectiveness and safety of using mifepristone as a non-emergency contraceptive.

Method:
Five databases including Medline, EMBASE, CINAHL, CABI Global Health and Cochrane Central Register of Controlled Trials were searched from inception until 12th of June 2025. Risk of bias was assessed using Cochrane risk of bias and ROBINS 1 tools and the Quality of the evidence was assessed using GRADE. J random-effects meta-analysis was performed for log-incidence rates to generate pooled Pearl indices (PI) and forest plots.

Results:
Thirteen studies met the inclusion criteria. Most were pilot studies with a high risk of bias. Several lower dosing regimens, including 0.5 mg daily and 5–10 mg weekly, were ineffective. The efficacy of monthly dosing was highly dependent on the timing of administration within the cycle, with greater effectiveness observed in the early luteal phase. Weekly administration of 25 or 50 mg showed the highest contraceptive efficacy with a PI of 0 for both dosages (95% CI: 0 – 20.5) and (95% CI: 0 –21.6) respectively. Both 5 mg daily and 25 or 50 mg weekly were associated with amenorrhea, with the highest proportion observed with the 50mg weekly regimen (12% of 222 cycles). Few adverse events were reported across all studies.

Conclusions:
While data are limited, the current evidence supports the use of mifepristone as a non-emergency contraceptive with a weekly dosing of 50mg showing the most promising results in terms of contraceptive effectiveness, bleeding profile and few adverse events. However, larger high-quality studies are needed to confirm its safety and efficacy.

P 6

Advancing personalized contraceptive care through an AI-driven decision support innovation for community and primary healthcare settings

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Background:
Contraceptive counseling in many low-resource settings remains limited by short consultation times, inconsistent access to trained providers, and reliance on static eligibility tools that assess safety without addressing individual preferences or lifestyle factors. As a result, many women experience dissatisfaction, poor adherence, and early discontinuation of contraceptive methods.

Objectives:
To develop and assess an AI-driven contraceptive decision support innovation that enhances personalized family planning counseling for women, pharmacists, and primary healthcare providers.

Methods:
A user-centered digital health framework was used to develop a prototype decision support platform based on the World Health Organization Medical Eligibility Criteria (WHO MEC). The intervention integrated medical eligibility screening with patient-centered variables including fertility intentions, adherence patterns, side-effect tolerance, privacy concerns, and prior contraceptive experiences.
The prototype underwent iterative usability and concept validation with women of reproductive age, pharmacists, and primary healthcare providers using simulated contraceptive counseling workflows. Participants interacted with structured questionnaires and received ranked contraceptive recommendations based on medical safety and lifestyle suitability. Descriptive qualitative analysis was used to assess usability, clarity, acceptability, and counseling support potential.

Results:
The prototype demonstrated feasibility and acceptability as a personalized contraceptive counseling innovation. Participants reported improved understanding of contraceptive options, expected side effects, duration of use, and adherence requirements. Healthcare providers identified the platform as useful for improving counseling consistency and supporting shared decision-making. Community users reported increased confidence in contraceptive decision-making due to the simplified interface and personalized recommendations.

Conclusions:
AI-driven contraceptive decision support systems may strengthen personalized reproductive healthcare delivery by combining evidence-based safety guidance with patient-centered decision support. The innovation demonstrates potential to improve contraceptive counseling quality, informed choice, and access to understandable family planning guidance in community and primary healthcare settings.

P 7

Pain experiences and barriers in intrauterine device (IUD) placement and Removal

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Background:
Pain management during the placement of intrauterine devices (IUDs) has become a subject of growing public debate in the Netherlands, raising questions about patient comfort, care standards, and the adequacy of current protocols.
Aims and Objectives: To investigate women's pain experiences during and after IUD placement and removal, and to identify the primary barriers preventing non-users from choosing this contraceptive method.

Methods:
An online survey was administered to a representative sample of women aged 18 to 49 in the Netherlands. The cohort was stratified into recent IUD users (n=584) and non-users (n=2196) over the past five years. Pain was quantified using a 0 to 10 scale. Statistical analyses were performed to identify demographic disparities, particularly regarding age and parity.

Results:
Among IUD users, 52% reported severe to unbearable pain (score 7-10) during placement. Pain intensity was significantly higher for nulliparous women (median score 7) compared to parous women (median score 4). During or immediately after the procedure, 40% experienced vasovagal symptoms such as dizziness or nausea, and 7% fainted. Post-insertion, 33% continued to experience severe to unbearable pain in the initial hours, and 25% experienced pain lasting longer than three days. Removal was also painful, with 25% reporting severe to unbearable pain (median score 4). Among non-users, fear of pain during placement or removal was a primary barrier for 29% of respondents, especially younger women.

Conclusions:
IUD insertion and removal cause severe pain and vasovagal symptoms for a substantial proportion of patients, disproportionately affecting younger and nulliparous women. Fear of this pain constitutes a significant barrier to IUD uptake. Standard pain management protocols must be critically re-evaluated to improve patient comfort and ensure equitable contraceptive accessibility.

P 8

Five-stage counselling framework for postpartum contraception in Slovenia

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Background:
Fertility may return soon after childbirth, often before the first postpartum menstruation, making timely contraceptive counselling essential. In Slovenia, unintended pregnancy rates remain high. In 2001, the induced abortion rate was 15 per 1,000 women aged 15–49 years compared with 40 per 1,000 among women within 12 months after delivery. Although the difference has decreased, postpartum women remain at increased risk; in 2023, the rates were 7 and 14 per 1,000, respectively.

Objectives:
To present a structured five-step counselling model for preventing unintended pregnancy and summaries evidence-based postpartum contraceptive recommendations according to breastfeeding status and venous thromboembolism (VTE) risk.

Methods:
International medical eligibility criteria and national guidelines were used. Evidence on return of fertility, contraceptive eligibility, contraindications, and counselling opportunities was summarized. Methods reviewed included long-acting reversible contraception, hormonal contraception, lactational amenorrhea method (LAM), emergency contraception, and barrier methods.

Results:
In breastfeeding women, menstruation typically resumes around 28 weeks postpartum and ovulation around 34 weeks, although reduced breastfeeding frequency may result in earlier fertility return. In non-breastfeeding women, menstruation commonly returns within 4–6 weeks and ovulation occurs on average around day 45 postpartum.
Immediate postpartum contraception offers important advantages because pregnancy can be excluded and initiation before discharge is practical. Intrauterine devices may be inserted within 48 hours after delivery or after 4 weeks postpartum, not affecting lactation. Progestogen-only methods can be initiated immediately postpartum, whereas combined hormonal contraception should be delayed because of elevated VTE risk. LAM is effective only with exclusive breastfeeding, amenorrhea, and during the first 6 months postpartum. Emergency contraception may be used after 3 weeks postpartum when indicated.

Conclusions:
Structured counselling during late pregnancy, before discharge, at 6 weeks, 3–6 months, and 1 year postpartum may improve uptake and continuation of effective contraception, reducing unintended pregnancies. Contraceptive choice should be individualized.

P 9

Contraceptive choices, sexual quality of life, and the persistence of traditional methods: a qualitative study

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Background:
The continued use of traditional contraceptive methods remains common globally despite the availability of highly effective modern options. Because of their lower efficacy, traditional methods are associated with higher rates of unintended pregnancy and contribute substantially to induced abortions.
Objectives. This qualitative study explored the influence of contraceptive use on women's sexual quality of life and examined reasons for the continued use of traditional contraceptive methods.

Methods:
A qualitative study using in-depth semi-structured interviews and purposive sampling was conducted across different regions of Slovenia. Data were collected in two phases (prior COVID-19 pandemic in 2020 and in 2024) from 65 women aged 20–74 years (mean age = 38.9 years, SD = 14.16) who had used at least one contraceptive method during their lifetime. Data were analysed using Braun and Clarke's six-phase thematic analysis, with data triangulation employed to enhance credibility.

Results:
Contraceptive pills had been used by 53 participants (81.5%). Three women (4.6%) reported exclusive use of intrauterine devices, four (6.2%) relied solely on condoms, three highly religious participants (4.6%) used only natural methods, and two (3.1%) reported lifelong reliance on withdrawal. Overall, 46 participants (70.8%) had used withdrawal at least once, and unplanned pregnancy was reported by 9 of them (19.6%). Women using modern contraceptive methods generally described positive effects on sexual satisfaction. Condom users reported reduced spontaneity, arousal, tactile sensation, and orgasm intensity. Users of natural methods were generally satisfied with their approach. Among withdrawal users, fear of pregnancy was associated with reduced sexual desire, and most reported negative effects on orgasm. Continued use of traditional methods was linked to religious beliefs, negative experiences with modern contraception, and preferences for perceived naturalness.

Conclusions:
The findings highlight the importance of cultural and individual factors in contraceptive decision-making and the growing influence of "natural" discourses in reproductive health.

P 10

Contraception before and after abortion: a local descriptive observational study, national context, and evolution of both populations

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Background:
Data from before and after abortion allows us to establish the use of contraception, its evolution, and evaluate the effect of contraceptive counseling.

Objectives:
- Analyze contraception before abortion and its evolution (Burgos-Spain)
- Compare both populations
- Analyze contraception after abortion and its evolution (Burgos-Spain)
- Compare both populations

Methods:
Descriptive observational study
Inclusion: Women who underwent medical abortion (Burgos) 2022-2025
Exclusion: Surgical abortion. >12 weeks of gestation. Contraindication
Abortion data (Ministry of Health) 2022-2024
SEC Contraception Surveys 2022-2024

Results:
Burgos
962 women.
Prior contraception: No 47.5%, Barrier 34.4%, COCs 12.3%, Ring 2.1%.
Subsequent contraception: Barrier 16.6%, COCs 21.3%, Ring 7.9%, Copper IUD 14.4%, Implant 18.4%.
Abortion Spain
307,585 women.
Prior contraception: Barrier 25.6%, Mechanical 0.8%, Hormonal 15.8%, No 46.8%.
Contraception Spain
3536 women.
No 21.05%, Barrier 36.1%, COCs 17.5%, Copper IUD 2.95%, LNG IUD 4.4%, Vasectomy 4.15%.

Conclusions
Trends in Burgos: Increase No-use and POPs, stable Barrier, decrease COCs and Natural.
Trends in Spain: Decrease Hormonal, increase Others and No-use.
Comparison Burgos-Spain: Fewer Natural; more Barrier, Mechanical; similar Hormonal and No-use.
Evolution after abortion Burgos: stability No-use, COCs and Implant; increase Barrier, POPs, injectable, and LNG IUD; decrease Copper IUD.
Pre and post-procedure: Significant decrease Barrier, No-use; increase Hormonal, Mechanical.

General population trends: Decrease No-use, salpingectomy and vasectomy; increase LNG IUD, Natural; stability Barrier, COCs and Copper IUD.
Comparison Burgos-Spain: Significantly lower No-use, lower Barrier, more COCs, POPs, Ring, and Injectable; significantly higher Copper IUD, implant; similar LNG IUD; absence of Natural and lower Surgical.
Our study provides insight into contraceptive use prior to abortion in Burgos, including its specific characteristics, and post-abortion contraception (not recorded by the Ministry or other studies).
It is a very promising approach, although further analysis will be necessary to verify its statistical significance, gain a better understanding of our population, and improve contraceptive counseling.

P 11

Copper intra-uterine device: can copper cause gynecological diseases?

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We aim to evaluate the available evidence regarding health risks associated with copper intra-uterine device (CIUD), particularly about local and systemic toxicity
Copper is a heavy metal according to the periodic table of chemical elements and has been used as a pesticide in agriculture for 150 years. The European Union now wants to ban the use of copper in agriculture because of its toxicity to living organisms and its persistence in the soil. Given the various mechanisms by which copper is toxic to living organisms, what is the risk-benefit balance of a massive dose of copper—180 mg—meeting the endometrium, considering that the human body contains 50 to 120 mg of copper?
We conducted a literature review on PubMed, Google Scholar, any date, using the following keywords: copper and gynecological diseases, copper and endocrine disruption, heavy metal and gynecological diseases, metalloestrogen, heavy metal and premature ovarian insufficiency.
CIUD increases the flow of periods, and this mechanism is well known to be a risk factor for endometriosis. Copper overload promotes angiogenesis, which is implicated in several gynecological and neoplastic conditions Copper interacts with sex steroid receptor, thereby resulting in endocrine disruption. Copper as heavy metal is involved in premature ovarian insufficiency.
Copper is toxic to sperm, but how toxic is it to the endometrium? Cuproptosis is a copper-induced cell death mechanism. Its involvement in endometriosis and several gynecological diseases is now investigated, raising further concerns about CIUD.
CIUD was launched in the 1970s, in unwanted pregnancies context, women’s desire for emancipation and devastating consequences of clandestine abortions. New findings on copper toxicity in gynecological diseases could call into question the benefit-risk balance of CIUD. Women's sexual and reproductive health deserves better than a 1970s contraceptive cure. Many new and safe therapeutic alternatives are world-wide available.

P 12

Exploring women's preferences about a non-estrogen/progestin contraception and perceptions of mifepristone as a contraceptive option: a qualitative descriptive trial

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Background:
Undesirable side effects or contraindications for estrogen/progestin-containing hormonal contraception are common. Mifepristone, a selective progesterone receptor modulator, has proven to be a highly effective emergency and a potential non-emergency contraceptive. There are few medical contraindications for the use of mifepristone; hence, it could be an option for persons seeking a non-estrogen/progestin contraception. However, before introducing new contraceptive methods, it is essential to understand the preferences and needs of the persons who may choose to use them. In this study, we aimed to explore women's thoughts about a non-estrogen/progestin contraception.
Objectives: To investigate Swedish women's perspectives and opinions about a non-estrogen/progestin containing pill for contraceptive use and the perception of mifepristone as a contraceptive.

Method:
We used a qualitative descriptive design to obtain a deeper understanding of women's perspectives. We invited fertile, non-pregnant, Swedish- or English-speaking women seeking consultation for contraceptive use at two maternal health centers or one youth center in Gothenburg, Sweden. We used semi-structured one-to-one interviews lasting 30-60 minutes. The interviews were transcribed verbatim and analyzed by thematic analysis according to Braun and Clark. The outcome measures were a description of women's perspectives on 1) aspects of a new non-estrogen/progestin contraception 2) strategies for introducing a non-estrogen/progestin containing pill as a contraception; 3) mifepristone as a contraceptive pill; 4) introducing mifepristone as a contraceptive on the Swedish market.

Results:
Preliminary results: Three themes have emerged from interviews conducted with 9 women: 1) enthusiasm about a new option; 2) the need for objective and well-guided information about efficacy and side-effects; 3) no objections about mifepristone as a contraception. Final results will be completed in August.

Conclusions:
Preliminary conclusions are that women have a positive attitude towards a non-estrogen/progestin containing contraception, but introduction into the market will require a well-directed information campaign.

P 13

Immediate post-obstetric event contraception in colombia: identifying bottlenecks to equitable scale-up

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Objectives:
Immediate post-obstetric event contraception (IPOEC) is recognized by the World Health Organization (WHO) as a high-impact practice to extend birth intervals, prevent unintended pregnancies, and reduce maternal and neonatal morbidity and mortality. Although Colombia reports a high modern contraceptive prevalence (76%), significant inequities persist in access to IPOEC, particularly among rural, indigenous, and adolescent populations. This study aimed to identify and prioritize the bottlenecks limiting IPOEC scale-up in Colombia and propose strategies to address them.

Method:
A mixed-methods approach was used, combining secondary analysis of the 2015 National Demographic and Health Survey, review of five national family planning guidelines against WHO standards, a structured survey of 13 key stakeholders from the Ministry of Health, health service providers, and professional associations, and a consensus workshop applying the WHO bottleneck methodology and problem-tree analysis.

Results:
Seven bottlenecks were identified. The most critical was the availability of contraceptive supplies (score 3.5), reflecting shortages of contraceptive products and equipment, particularly long-acting reversible contraceptives, in primary care facilities. Other major bottlenecks included limited information, education, and communication materials on IPOEC (3.38), inadequate health promotion strategies (3.25), insufficient dissemination of effective innovations (3.22), and gaps in human resource capacity, training, and community participation (3.0 each). Policy review demonstrated partial alignment with WHO recommendations, identifying gaps in family planning counseling during immunization visits and following out-of-facility births. Secondary data showed that only 32.9% of postpartum women accessed IPOEC, while women living in rural areas and the Atlantic region were 1.3 to 2 times less likely to receive contraceptive information.

Conclusion:
Expanding IPOEC in Colombia requires strategic financing, continuous pre-service and in-service training, culturally adapted information and communication materials, stronger community engagement, improved coordination with health insurers to facilitate contraceptive delivery, and expanded telemedicine. Addressing these bottlenecks is essential to translate national policy into equitable access to postpartum and post-abortion contraception.

P 14

“The doctor was pulling and pulling”: patient experiences of difficult IUD removals

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Background:
Intrauterine devices (IUDs) are popular long-acting reversible contraceptive methods. While they are designed to be easily removed, patients sometimes experience challenging removals.

Objectives:
To describe social media discourse surrounding IUD user experiences with difficult removals.

Methods:
Utilizing predefined search terms, we searched the r/CopperIUD, r/Mirena, r/birthcontrol, and r/IUD Reddit communities for posts about difficult IUD removal experiences. Two researchers reviewed each post to confirm relevance. We used ATLAS.ti Cloud to conduct a qualitative analysis of post content.

Results:
We analyzed 80 posts and 714 associated comments (794 narratives). Users turned to Reddit to share experiences, seek emotional support, and obtain advice. Many were blindsided and frustrated towards clinicians (“these doctors don’t tell us that could be a risk”). Almost universally, they experienced significant pain during removal attempts (“it literally felt like my uterus was being tugged out of my body”), with clinicians minimizing patient experiences (“I felt like everyone was gaslighting me”). Many described needing “surgical removals” with some experiencing significant wait times. Reddit was a source of clinical information: “my IUD is embedded and they’ll have to refer me to a gynecologist who has ‘better tools.’ I’m curious what to expect from here”. Users also encouraged others to advocate for themselves (“be insistent on the use of numbing and sedation medication. They have the capability to make this a less traumatic process and are choosing not to spare you.”). Never using an IUD again was a common theme, with some posters discussing how to take “legal action”.

Conclusions:
There is a need to improve transparency, validate patient experiences, and address pain when it comes to IUD insertions and removals.

P 15

“10 appointments, 4 ultrasounds, 2 x-rays”: experiences of difficult implant removals

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Background:
Rarely, subdermal contraceptive implants may be difficult to remove, requiring additional procedures and leading to delayed removals.

Objectives:
To describe social media discourse surrounding contraceptive implant user experiences with difficult removals.

Methods:
Utilizing predefined search terms, we searched the r/birthcontrol and the r/Nexplanon Reddit communities for posts about difficult contraceptive implant removal experiences. Two researchers reviewed each post to confirm relevance. We used ATLAS.ti Cloud to conduct a qualitative analysis of post content.

Results:
We analyzed 31 posts and 176 associated comments for a total of 207 narratives. Many users were surprised when their implant was difficult to remove, as were their clinicians, many of whom had “never seen” this before. Month-long delays, multiple visits with clinicians, and various imaging modalities were common. Many users experienced painful, prolonged removal attempts, with clinicians “digging around” their arms, often with inadequate pain management. Users mentioned successful removals by general surgeons, orthopedic surgeons, interventional radiologists, and gynecologists with “superior surgical skills”. Some users reported neurological symptoms after difficult implant removals, and many stated they would “never again” consider implants. Users reported feelings of isolation and turned to Reddit for advice (“has anyone else seen this happen?”), to “raise awareness about this problem”, and to validate concerns about having received inadequate care (“She was digging around in my arm for 20 minutes to take the old one out so I just think she didn’t know how to do it properly.”).

Conclusion:
Clinicians inserting and removing implants need adequate training and access to clear referral pathways for safe removal of deep or nonpalpable implants.

P 16

Choice of contraception at the postpartum visit: a cross-sectional study from the Swedish Pregnancy Register

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Background:
Postpartum contraception (PPC) use remains low globally, warranting further research on associated factors.

Objectives:
The objectives of this study were to determine the prevalence of PPC, types of methods chosen, and their associations with sociodemographic and obstetric characteristics.
We conducted a cross-sectional study in three Swedish regions using 2022 data from the Swedish Pregnancy Register. Participants were women with live births who attended a maternal health clinic 4–16 weeks postpartum.

Methods:
Effective methods (Pearl Index ≤9) included LARCs, SARCs, and sterilization; fewer effective methods included condoms, diaphragms, LAM, withdrawal, and cycle-based methods. Analyses used chi-square tests, t-tests, and multinomial logistic regression.
A total of 22793 patients were included, with a PPC prevalence of 77.6%. Effective methods were chosen by 50.9% with intrauterine devices (25.1%) and pills (18.5%) being the most common. Less effective methods were chosen by 26.7%, mainly barrier methods such as condoms and diaphragms (21.2%). Additionally, 22.4% chose no method.

Results:
A higher relative probability of choosing a *less effective* or *no method* was found among those who were: older (RRR 1.03, 95% CI 1.02-1.04 or RRR 1.08, 95% CI 1.07-1.09), born outside the Nordic countries in Europe (RRR 1.61, 95% CI 1.43-1.83 or RRR 1.38, 95% CI 1.20-1.57), born outside Europe (RRR 1.44, 95% CI 1.33-1.58 or RRR 1.14, 95% CI 1.04-1.26), breastfeeding partially (RRR 1.28, 95% CI 1.14-1.44 or RRR 1.30, 95% CI 1.15-1.47) or breastfeeding totally (RRR 1.39, 95% CI 1.26-1.54 or RRR 1.43, 95% CI 1.28-1.58).

Conclusion:
We found a high prevalence of PPC, with a higher likelihood of choosing l*ess effective* or *no methods* postpartum among patients who were older, born outside the Nordic countries or breastfeeding. Understanding factors linked to PPC choice can help tailor interventions, support informed decision-making and improve access to effective PPC, aiming to enhance equal healthcare for all.

P 17

When algorithms silence sexual health: Navigating digital censorship to drive real world outcomes.

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Background:
Digital advertising platforms are central to health promotion; however, automated moderation systems frequently misclassify medically accurate sexual health content as "sexually explicit," limiting reach. This reflects broader structural stigma, where sexual health messaging is disproportionately suppressed, compounding existing barriers to care for populations already underserved.

Objectives:
This presentation examines the impact of algorithmic censorship on sexual health campaign delivery in Australia and evaluates adaptive strategies to maintain reach and effectiveness. A specific objective was to improve engagement among young men aged 18 to 34, a population disproportionately underscreened and underreached in STI prevention, testing and treatment.

Method:
Sexual and Reproductive Health Australia (SRHA), in partnership with Sexual Health Victoria, delivered a national STI awareness campaign across Australia. A dedicated platform account manager was engaged prior to launch, campaign budgets preloaded, and multiple policy reviews submitted. Rejected advertisements were escalated and language refined to meet platform constraints. Optimisation shifted from impression-based to click-driven metrics. Short, authority-led video content replaced longer-form assets to reduce moderation risk and improve performance.

Results:
Despite initial reductions in display reach, optimisation strategies strengthened overall engagement. Google advertising achieved a click-through rate of 8.77%, significantly exceeding national healthcare benchmarks. The campaign generated more than 37,000 unique "Book Now" clicks, contributing to a 13.2% increase in clinic appointment bookings across Australia. The highest engagement was observed among males aged 18 to 34, demonstrating that adaptive, data-driven strategies can reach populations traditionally underserved.

Conclusions:
Algorithmic moderation is a structural barrier to equitable health communication and access to care. However, strategic agility, diversified media investment, and proactive platform engagement can mitigate censorship impacts. Embedding risk mitigation into campaign design is essential to ensuring continued access to accurate, stigma-free sexual health information for underserved populations in increasingly regulated digital environments.

P 18

Oral hormonal contraception to improve skin appearance

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Background:
Some skin problems among women of reproductive age are caused by sexual hormone imbalance, a condition known as hyperandrogenemia, the first line of treatment for which is oral hormonal contraception (OHC). The use of OHC has always been controversial.

Objectives:
To investigate how women of reproductive age with some dermatological conditions are motivated and educated to use OHC to improve their skin appearance.

Methods:
A group of 90 young women who had recently started OHC was given a questionnaire about their reasons for starting OHC, their feelings about the information and care they had received from their Ob/Gyns, and their satisfaction with the counseling they received about OHC use. These data were analyzed using appropriate statistical methods.

Results:
The participants' mean age was 20.9 (17-27 years). The reasons for using OHC were contraception, 52%; menstrual period regulation, 24%; dermatological reasons, 7%; menstrual period regulation and dermatological reasons, 3%; contraception and dermatological reasons, 2%; and multiple reasons, 12%. Before starting OHC, their Ob/Gyns advised them of the laboratory tests (in cases of inappropriate medical history data) needed to determine any risk to using the method. If there were no contraindications to OHC, they were instructed on how to use the OHC intake. All women (100%) were satisfied with the information and care they received, with 20% strongly confirming this.

Conclusion:
Acne, oily skin, and hirsutism are the most commonly reported skin conditions among women of reproductive age; the best results are when these conditions are treated collaboratively by gynecologists and dermatologists. It is important to encourage women to begin using the OHC prescribed to them, so that they may expect the best possible treatment results.

P 19

Negotiating reproductive health: experiences of patients seeking sterilization in gynecological care

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Background:
Voluntary female sterilization (VFS), including tubal ligation or occlusion, as a permanent method of contraception, remains an underexplored research field in Germany. While VFS aligns with the human right to reproductive justice, access to sterilization care is often limited. These constraints on reproductive autonomy can have significant consequences for patients' health, including psychological distress, pain, mistrust in healthcare providers and discontinuity of care.

Objectives:
To explore how individuals seeking voluntary sterilization in German outpatient gynecological care experience constraints on their reproductive autonomy and disrespectful care practices, and to examine the perceived consequences of these for their health and healthcare utilization.

Methods:
In the context of a study on negative experiences of gynecological care in Germany, we conducted 7 interviews and one focus group with individuals (n=4) having sought or still seeking sterilization. The content of the interviews was analyzed thematically.

Results:
Patients seeking VFS face multiple, intersecting constraints on their reproductive autonomy. These occur on a structural level (e.g. referral requirements and dependence on gynecologist approval), institutionally (e.g. practice-specific age restrictions, denial of sterilization appointments), and on a relational level between physician and patient. Patients experience the need to actively negotiate their reproductive rights, while they report being paternalized, disrespected and insufficiently informed, with physicians disregarding their individual needs. Reported health consequences include psychological distress, lack of care and restricted reproductive autonomy.

Conclusions:
The study reveals deficits in reproductive autonomy regarding individuals seeking sterilization in gynecological care in Germany. Patient´s experiences show predominantly preventable health consequences associated with disrespectful, paternalistic care practices. It highlights the need for empathetic, equitable and patient-centered gynecological care in relation to sterilization consultations.

P 20

Clinical practice guidelines for first-line contraception for fertile aged women, teenagers and postabortion/postpartum, a systematic review

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Background:
Clinical practice guidelines for contraception are crucial to ensure access, equity and informed choices for both contraceptive methods and services. Differing guidelines may lead to disparities in the standard of care and contraceptive options worldwide.

Objectives:
To compare first- and second-line contraceptive recommendations in clinical practice guidelines for the prevention of unintended pregnancy and to assess how these recommendations vary for adolescents, postpartum, and post-abortion populations.

Methods:
A systematic literature search of clinical contraception guidelines, published or updated from 2010 onward, was conducted in 2025 using PubMed, Scopus, Web of Science, DynaMed, GIN, TRIP, and Medibas. Guidelines in languages other than English, Finnish, or Swedish were translated using DeepL. Each guideline was independently evaluated by two researchers with discrepancies discussed among all authors. Quality assessment will be performed using the AGREE-II tool.

Results:
A total of 2389 articles were identified. After exclusion of irrelevant articles and duplicates, 265 documents were assessed for eligibility. After full-text screening, altogether 36 guideline documents from 18 countries were included. Each national guideline was treated as one entity although some countries had divided theirs into multiple smaller articles. Preliminary findings display differing recommendations across guidelines in the progestin and estrogen component of the combined oral contraception pill. Several recommendations prioritize the use of long-acting reversible contraception (LARC)and many guidelines emphasize the women´s right to choose contraceptive method, in the absence of contraindications.

Conclusion:
National clinical practice guidelines for contraception vary in how first- and second-line methods are recommended across countries. Most guidelines do not highlight a specific contraceptive method as a first or second-line recommendation at all, although many emphasize the contraceptive efficacy of LARC methods. Our preliminary findings underline the need for transparent, evidence-based, and patient-centered guideline recommendations to support equitable contraceptive services.

P 21

Pregnancy Wantedness, Contraceptive Prescriptions, and Mental Health in Dutch General Practice

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Background:
Contraceptive non-use, inconsistent use, and mental health problems have previously been associated with unintended pregnancies. However, the relationship between contraceptive use, mental health problems, and pregnancy wantedness remains unclear.

Objectives:
To examine contraceptive prescription patterns before and after pregnancy in relation to pregnancy wantedness and preconception mental health problems.

Methods:
This retrospective cohort study used electronic health records of 157,640 women aged 16–49 from three Dutch primary care research networks (2015–2021).
Contraceptive prescriptions and mental health problems were compared across women with wanted, unwanted, and no pregnancies. Further analyses focused on women with wanted and unwanted pregnancies, examining preconception contraceptive prescriptions, mental health problems, and postpartum contraceptive prescriptions using regression analyses.

Results:
Overall, 1,771 (1.1%) women had an unwanted pregnancy, 22,482 (14.3%) a wanted pregnancy, and 133,387 (84.6%) no pregnancy. LARC methods were prescribed more often to women with unwanted pregnancies than to women with wanted or no pregnancies. Women with unwanted pregnancies were prescribed more contraceptive methods than women with wanted pregnancies and no pregnancy ($p \leq 0.001$).
Before pregnancy, COCP was prescribed more often among women with unwanted pregnancies (18.9% vs. 15.1%; $p < 0.001$). Substance use (aOR = 3.33, 95% CI 2.05–5.41) and other mental health problems (aOR = 1.58, 95% CI 1.28–1.96) were associated with higher odds of unwanted pregnancy.
Postpartum, women with unwanted pregnancies more often received LARC, COCP, and vaginal ring prescriptions, while progestogen-only pills were prescribed less often among women with wanted pregnancies.

Conclusions:
Women with unwanted pregnancies more often received contraceptive prescriptions before and after pregnancy, suggesting that unwanted pregnancy does not necessarily reflect a lack of contraceptive prescribing. Challenges related to consistent use, method switching, and mental health problems may contribute to unwanted pregnancies. These findings highlight the importance of psychosocial factors and personalized contraceptive counselling.

P 22

"For my own safety and peace of mind": views on contraception among young emergency contraception users: a qualitative study in Swedish Pharmacies

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Background:
Despite well-established contraceptive care services in Sweden, there remains an unmet need for contraception. Emergency contraceptive pills are provided over the counter in pharmacies without subsequent contraceptive counseling. Use is widespread, yet research on Swedish emergency contraceptive users is limited. Understanding their experiences is important for tailoring contraceptive care to their needs.

Objective:
To explore young emergency contraceptive pill users' experiences and perceptions on contraceptive decision-making and contraceptive use.

Methods:
We performed a qualitative content analysis with an inductive approach on semi-structured interviews in 10 participants between 17-26 years old, who purchased emergency contraceptive pills in community pharmacies in Stockholm, Sweden.

Results:
The theme 'Navigating reproductive autonomy through perceptions, information and norms was identified, supported by three categories; (i) Emergency contraception at pharmacies facilitates reproductive autonomy, where participants shared their appreciation of easy access (ii) Internal perceptions and external information sources affect contraceptive use, considering factors such as one's personal situation and social media and (iii) Perceived social norms and their role in contraceptive experiences, where influences from social context and perceived stigma were mentioned.

Conclusion:
To support informed decision-making and reproductive autonomy, providers need to ensure easy access to contraception, whilst sustaining non-judgmental environments and actively countering myths and misconceptions with accurate, evidence-based information both offline and online.

P 23

“My body did not behave.” A qualitative study about user experiences with difficult IUD removals

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Background:
While IUDs are designed to be easily removed, missing strings, embedded or perforated IUDs may require additional interventions. This study examines the experiences of individuals whose IUDs could not be removed on the first attempt.

Objective:
This is a qualitative study conducted according to the principles of grounded theory. We used social media to recruit Spanish and English-speaking individuals residing in the United States to participate in semi-structured interviews about their difficult removal experiences. We tape-recorded and transcribed interviews, then double-coded each transcript. The New York Medical College Institutional Review Board approved the study.

Methods:
We conducted 28 interviews between March and May of 2026. Many participants reported feeling surprised and “unprepared” when they realized their IUDs could not easily be removed. Clinicians were similarly ill-equipped to explain these scenarios, saying for example that they “couldn’t tell how [the IUD] had gotten out of the uterus”. Respondents often believed that their own anatomy caused IUDs to become embedded or “migrate” (“how my body behaved, that was the problem”). Participants also described needing to advocate for themselves, returning for multiple appointments and requesting imaging studies (“he was telling me that [the IUD just] kind of came out, but I knew that it hadn’t [...] I had to push for [the X-ray]”). Many ultimately had surgical removals after multiple failed attempts and scheduling delays. Poor communication from clinicians and dismissal of participants’ pain were pervasive. Despite these negative experiences, some participants said they would recommend an IUD to others but would give them a “heads up [because] it's going to really hurt. Bring your own heating pad. See if your doctor will offer you some medication.”

Conclusions:
IUD users and clinicians alike are often unprepared for difficult IUD removals. Training initiatives for clinicians should address strategies for difficult removals and management of pain during office procedures.

P 24

Picture this: a comparison of two visual aids for contraceptive counseling

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Background:
To date, the optimal method for providing the information about available methods of contraception has not been established. Partners in Contraceptive Choice and Knowledge (PICCK) developed a new visual aid that groups methods based on different attributes. The guide was translated into several languages. Limited data are available on patient perspectives on this new aid, particularly as it compares to the common WHO (or similar) efficacy chart. We conducted a pilot study comparing patient perceptions of the WHO and PICCK visual aids.

Objectives:
We recruited individuals to participate in a simulated contraceptive counseling session, exposing each person to both aids. Interviewers conducted the sessions utilizing a standardized script, then asked closed and open-ended questions about each aid and comparing the two. We tape-recorded and transcribed each session, coded, and analyzed responses.

Methods:
A total of 20 English and 20 Spanish-speaking patients participated in the study between June 2025 and March 2026. 96% had previously used contraception. With both visual aids, participants liked seeing all the options in one place, and many discovered methods that they had never heard of before. Participants liked the graphics of the PICCK, as well as knowing which methods contained hormones and what side effects they could cause, but some felt it was “a lot of words” to read. Participants appreciated the simplicity of the WHO aid but many felt it left questions unanswered. For the WHO aid, 4% stated it would be very helpful if they were choosing a contraceptive method, while 96% said so about the PICCK aid. When asked to choose which aid they preferred, almost all (94 %) would choose the PICCK aid.

Conclusion:
Visual aids are useful for providing patient-centered contraceptive counseling. Many individuals prefer appealing graphics and comprehensive information over a simple graphic focused on efficacy when making contraceptive decisions.

P 25

Effect of universal, no-cost contraception coverage on hysterectomy volume: a population-based interrupted time series analysis

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Background:
One third of females in Canada will have a hysterectomy in their lifetime, with nearly 100,000 hysterectomies performed annually. Most (70-80%) of hysterectomies are performed to manage abnormal uterine bleeding. Hormonal contraception (levonorgestrel-releasing IUD or combined oral contraceptive pill) is the recommended first-line therapy for abnormal uterine bleeding. Improved contraception access may reduce the need for hysterectomy for abnormal uterine bleeding. In Canada, physician visits and procedures are covered through public insurance; prescription medications/devices are paid through a mix of public-private insurance or out-of-pocket by patients. In 2023, the province of British Columbia (BC) introduced universal no-cost coverage for contraception. This policy substantially increased contraception use, though impacts on hysterectomy volume are unknown.

Methods:
We used population-based linked health administrative data (physician billing, hospitalization, emergency department records) to identify hysterectomy procedures among female BC residents age 30-50 from 2021-2024. We excluded events with a recent cancer or uterine prolapse diagnosis. We used an interrupted time-series analysis to estimate the effect of BC's contraception coverage policy change on the level and trend changes in monthly hysterectomy rates per 100,000 females. We compared observed to expected (counterfactual) rates 21 months after the policy change (December 2024).

Results:
There were 22,429 hysterectomies performed in BC from 2021-2024, with 17,261 (77%) performed for abnormal uterine bleeding. Pre-policy, there were 23 procedures per 100,000 females/month, increasing by 0.25 per month. After the policy change, there was an immediate reduction (-3.4 hysterectomies/month; CI −1.7, -5.1), followed by a significant decline in the trend. By December 2024, there were 5 fewer procedures per 100,000 females/month than expected without the policy change, amounting to a 17% volume reduction.

Conclusion:
Universal no-cost contraception coverage significantly reduced hysterectomy volume. Expanded contraception access may reduce demand for resource-intensive procedures to manage abnormal uterine bleeding.

P 26

From care to contraception: linking maternity services to postpartum contraceptive uptake in India

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Background:
Despite improvements in maternal healthcare utilization in India, postpartum modern contraceptive uptake remains suboptimal among young women, increasing the risk of closely spaced and unintended pregnancies. The continuum of maternity care presents a critical opportunity to promote early contraceptive adoption, yet its potential remains underutilized.

Objectives:
This study examines the effect of maternity service utilization on the timing and likelihood of postpartum contraceptive uptake.

Method:
Using reproductive calendar data from the 2015–16 and 2019–21 National Family Health Survey, the study focuses on currently married women aged 15–24 years with a recent birth. A time-to-event framework was applied to assess contraceptive initiation within 12 months postpartum. Kaplan–Meier estimates and Cox proportional hazards models were used to derive adjusted hazard ratios (AHRs), controlling for socio-economic and demographic factors.

Results:
Postpartum contraceptive uptake increased from 33% to 42% over time, indicating modest progress. Women receiving ≥4 antenatal care visits had a significantly higher likelihood of adoption (AHR: 1.589; 95% CI: 1.493–1.691; p<0.001 in 2015–16; AHR: 1.333; 95% CI: 1.267–1.403; p<0.001 in 2019–21). Institutional delivery was positively associated with uptake (AHR: 1.113 and 1.217; p<0.001), as was postnatal care within 42 days (AHR: 1.274 and 1.193; p<0.001). Higher education, wealth, and parity significantly increased adoption likelihood (p<0.001). However, delayed initiation persisted, with many women remaining unprotected during early postpartum months.

Conclusions:
Maternity services significantly enhance postpartum contraceptive uptake, but gaps in timely adoption persist. Integrating family planning counselling across the maternal care continuum is essential to reduce missed opportunities and improve reproductive health outcomes.

P 27

Do contraceptives reduce adverse pregnancy outcomes among young women in India

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Background:
Adverse pregnancy outcomes (APOs) among young women pose a persistent challenge to maternal and reproductive health in India. Despite ongoing family planning initiatives, the relationship between contraceptive use and pregnancy outcomes remains insufficiently explored.

Objective:
This paper aimed to examine the effect of type of contraception uptake on pregnancy outcomes among young women in India.

Method:
This study draws on nationally representative data from the National Family Health Survey (NFHS) 2015–16 and 2019–21, focusing on married women aged 15–24 years with a recent pregnancy. Pregnancy outcomes were classified as live birth, miscarriage, abortion, and stillbirth. The key explanatory variable was type of contraceptive use, categorized into non-use, short-acting reversible contraceptives (SARCs), long-acting reversible contraceptives (LARCs), and permanent methods. Multinomial logistic regression models were employed to estimate adjusted odds ratios (AORs), controlling for demographic, socio-economic, and maternal health factors.

Results:
Between survey periods, the proportion of live births declined, while adverse pregnancy outcomes increased, particularly miscarriages. Compared to non-users, women adopting contraceptive methods demonstrated significantly lower risks of APOs. Use of LARCs showed the strongest protective effect, with markedly reduced likelihood of miscarriage and abortion, followed by SARCs. Even after adjustment, contraceptive use remained a robust predictor of improved pregnancy outcomes. Additionally, maternal age, anaemia status, antenatal care utilization, parity, and socio-economic status were independently associated with the risk of APOs ($p < 0.05$).

Conclusions:
This study provides compelling evidence that contraceptive uptake, particularly long-acting methods, substantially reduces the risk of adverse pregnancy outcomes among young women in India. Expanding access to LARCs, addressing unmet need for contraception, and strengthening integrated maternal health services are essential for mitigating preventable reproductive risks. Policy efforts must prioritize equitable access, informed choice, and quality family planning services to accelerate progress toward improved maternal health outcomes.

Counselling

P 28

Post-abortion contraception in Slovenia: five-stage counseling framework

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Background:
Induced abortion reflects unintended pregnancy and remains an important indicator of sexual and reproductive health. In Slovenia, the induced abortion rate among women aged 15 – 49 years declined from 42.0 per 1,000 women in the early 1980s to 7.2 per 1,000 women in 2024. National abortion data are highly reliable because abortion is legal, accessible, and covered by compulsory health insurance. Despite this decline, women who have undergone an abortion remain at increased risk of repeat unintended pregnancy and subsequent abortion.

Objectives:
To present evidence-based recommendations for contraception after abortion in Slovenia and to introduce a structured five-step counselling model aimed at reducing repeat unintended pregnancies and improving long-term contraceptive use.

Methods:
National epidemiological data, Slovenian clinical recommendations, and international medical eligibility criteria for contraceptive use were reviewed. Evidence on return of fertility, timing of contraceptive initiation, and counselling strategies was synthesised to develop a structured model for contraceptive counselling throughout abortion care and follow-up.

Results:
In the first year after abortion, the abortion rate is approximately 8.1 times higher than in the general reproductive-age population, remaining 3.9 times higher in the second year and 3.2 times higher in the third year. Ovulation resumes rapidly after abortion, highlighting the importance of timely contraceptive counselling and initiation. A five-step model was developed comprising counselling at referral, contraceptive initiation at abortion, follow-up at 2 – 3 weeks, reassessment at 3 months, and long-term follow-up at 1 year.

Conclusions:
Despite the increased risk of repeat abortion among women following an abortion, Slovenia has achieved one of the lowest abortion rates in Europe through accessible and free reproductive healthcare services. Continued implementation of structured post-abortion contraceptive counselling may help sustain and further improve these favorable reproductive health outcomes.

P 29

Improving patient information in medical abortion through a mifepristone–misoprostol combination pack: a two-study assessment of prescriber and end-user priorities in France

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Background:
Patient information remains a primary unmet need in medical abortion, particularly regarding bleeding, pain, warning signs, and procedure experience. In France, mifepristone and misoprostol are supplied separately, often without adequate information. A combination pack could close this gap if designed around prescriber and end-user priorities.

Objectives: To identify women's needs for information and support during medical abortion. Define which information should be provided by a patient-centered mifepristone–misoprostol combination pack.

Methods:
Two complementary studies were conducted in France in 2026. Study-1 surveyed 225 community-based prescribers (75 gynecologists, 75 GPs, 75 midwives) on practices, patient experience, and topics requiring re-explanation. Study-2 was a qualitative user test including nine women (with/without prior abortion experience), one midwife and one GP, evaluating pack clarity, reassurance, and recognition of warning signs.

Results:
Prescribers described medical abortion as emotionally difficult and highly variable experience and rated current packaging as problematic for readability and step differentiation. Patient questions most often concerned pain and symptoms (63%), bleeding and expulsion (27%), long-term consequences (26%), fertility (24%), efficacy (24%) and safety (23%). Topics most often re-explained were emergencies (27%), procedure protocol (26%), follow-up (24%) and intake (23%). All nine women correctly identified the medical purpose, two-step treatment and 36–48h interval. They rated the pack as reassuring. However, 89% found the misoprostol step confusing and 44% partially identified emergency warning signs. Reviewers flagged gaps on when to recontact prescribers versus seeking emergency care, analgesia timing, and contraception resumption.

Conclusions:
Prescribers and end-users converge on priority information: a clearly staged intake sequence, explicit normal-versus-warning thresholds for bleeding and pain, unambiguous emergency signs, and reassurance on long-term consequences. An illustrated notice with key contacts and dates, paired with complementary digital support, could close comprehension gaps and enable safer at-home self-management abortion.

Education

P 30

Knowledge as connective tissue for locally led safe abortion action in Cameroon

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Background:
In Cameroon, abortion is restricted and stigmatised. Unsafe abortions cause many maternal health problems and deaths. Community workers, doctors, pharmacists, activists, and researchers each know different things about abortion, but this knowledge stays separate instead of being shared to improve care.

Objectives:
To identify how abortion knowledge moves between different groups in Cameroon and determine practical ways to connect this knowledge for safer abortion care.

Methods:
Study design: Qualitative study. Sites: Two urban areas (Buea, Douala) and two rural communities (North-West, South-West regions). Target population: People working directly with abortion issues. Sample size: 30 interviews, 3 focus groups (9-12 people each). Sampling technique: Purposive (selecting knowledge experts) then snowball (referrals). Data collection: Semi-structured interviews and focus groups asking: "What do you know about abortion? How did you learn it? Who do you share it with?" Analysis approach: Thematic analysis to find patterns in knowledge types and blockages; network mapping to see connections. Ethical considerations: Informed consent, fake names, secure data storage, safety checks. Inclusion criteria: Adults with 1+ year abortion experience. Exclusion criteria: Minors or no direct experience.

Results:
Analysis found these main patterns:
Knowledge silos: Community workers knew informal providers and real-life problems; doctors knew treatment guidelines; pharmacists tracked abortion pill sales; researchers had laws and numbers.
Sharing barriers: Fear of arrest (22 people said this), professional walls (18 mentions), donor forms (14), community mistrust (12).
Working solutions: Case discussions, WhatsApp groups, joint trainings improved referrals and spotting problems early.
Connection methods: Learning circles (doctors + community), safe messaging apps, shared guides.

Conclusions:
Abortion knowledge exists but doesn't connect well. Simple sharing like learning circles and safe apps can build local systems to reduce unsafe abortions and improve care.

P 31

A midwife-led quality improvement initiative to strengthen early detection and escalation of maternal deterioration during the latent phase of labour and immediate postpartum period.

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Background:
Delayed recognition and response to abnormal maternal clinical parameters during the latent phase of labor and the immediate postpartum period contribute to preventable maternal morbidity, particularly in high-volume, resource-limited settings. Structured monitoring approaches for these periods are often limited.

Objectives:
To improve early detection, documentation, and timely escalation of abnormal maternal clinical parameters during the latent phase of labor and the immediate postpartum period through a midwife-led quality improvement initiative.

Methods:
A quality improvement initiative was conducted in a quaternary referral hospital. Two simplified paper-based tools were developed: a latent-phase labor monitoring chart for cervical dilatation <5 cm, and a structured fourth-stage postpartum chart. Both tools incorporated routine monitoring of blood pressure, temperature, respiratory rate, oxygen saturation, heart rate, and urine protein, with predefined thresholds to trigger escalation. The tools were introduced through staff orientation and supportive supervision without additional resources. Process indicators included tool utilization, completeness of documentation, and escalation of abnormal findings.

Results:
Tool utilization exceeded 80% and was sustained over 18 months. Completeness of vital signs documentation improved from an estimated baseline of 50–60% to over 85%. Detection and documentation of abnormal clinical parameters increased, with improved timely escalation of care. Midwives reported enhanced confidence, consistency in monitoring, and improved accountability in care delivery.

Conclusions:
Structured monitoring tools with clear escalation triggers can strengthen early detection and response to maternal deterioration during the latent phase of labor and the immediate postpartum period. Midwife-led, low-cost interventions are feasible and sustainable in resource-constrained settings and have the potential to improve maternal safety and quality of care.

P 32

From Sstorytelling to social change: youth-led digital and community strategies to reduce abortion stigma in Lagos, Nigeria

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Background:
In Nigeria, abortion stigma, often intersecting with HIV, gender-based violence, and disability limits access to accurate information and safe services, particularly for young people. Digital platforms and youth-led spaces offer opportunities to reshape narratives but remain underutilized. IRISE, through the 'to ba se wo' (If it were you) 360 Pamoja communication project implemented a multi-channel, youth-centered approach to amplify voices, reduce stigma, and build support for safe abortion and the reinstatement of the Safe Termination of Pregnancy (STOP) guideline in Lagos State.

Objectives:
To assess the effectiveness of youth-led digital engagement, storytelling, and community dialogue in improving knowledge and shifting attitudes toward safe abortion and SRHR.

Methods:
Between May 2024 and January 2025, IRISE implemented a mixed-methods intervention in 5 communities across two LGAs in Lagos State. Activities included six virtual sessions engaging 920 participants, community dialogues with theatre in five communities reaching 756 participants, live radio discussions, youth-led storytelling and peer engagement. Pre- and post-session surveys assessed changes in knowledge, attitudes, and advocacy readiness.

Results:
- 91.7% reported storytelling can reduce stigma
- 87.5% felt more comfortable discussing SRHR
- 83.3% felt empowered to share experiences
- 100% improved understanding of stigma and gender dynamics
- 68.4% supported women's reproductive rights
- 57.9% remained unclear about abortion legality

Radio platforms further expanded public engagement and dialogue.

Conclusions:
Youth-led digital and community strategies effectively reduce stigma and strengthen advocacy capacity. However, persistent legal knowledge gaps highlight the need for sustained education. This model offers a scalable approach for advancing stigma-free SRHR advocacy in restrictive settings.

P 33

Accessing barriers to safe abortion among female sex workers in Cameroon.

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Background:
Unsafe abortion remains a critical public health and human rights issue among marginalized populations, particularly female sex workers (FSWs) in crisis-affected settings such as Cameroon. FSWs face overlapping vulnerabilities, including poverty, stigma, and displacement—that limit their access to safe and legal abortion services. This study examined barriers to safe abortion, documented lived experiences, assessed knowledge gaps, and generated evidence to inform advocacy in Limbe and Buea.

Objectives:
A convergent mixed-methods approach was used, combining quantitative data from 118 FSWs with qualitative insights from two focus group discussions involving 18 participants. Quantitative analysis included descriptive statistics, composite indices (knowledge, stigma, vulnerability), and regression analysis using R, while qualitative data were analyzed thematically and triangulated.

Methods:
Findings reveal a highly vulnerable population: over 98% identified as sex workers, 90.6% reported low income, and 66.7% were internally displaced. Knowledge gaps were significant, with 81.35% lacking awareness of abortion legality. Stigma emerged as the primary barrier, reported by 52.5% of participants, alongside widespread perceptions of provider judgment (62.6%). Financial and informational constraints further limited access, with more than 65% experiencing multiple overlapping barriers. Regression results showed that low income, displacement, and geographic location significantly influenced perceptions of provider bias. Qualitative findings reinforced these patterns, highlighting fear of judgment, lack of confidentiality, and restrictive provider practices as major deterrents. Unsafe abortion was associated with severe consequences, including mortality, infertility, and psychological distress. Despite some awareness of abortion methods, knowledge of legal rights and available services remained critically low.

Conclusion:
The study concludes that unsafe abortion risks among FSWs are driven by intersecting structural and social factors. Addressing these challenges requires integrated interventions, including stigma reduction, improved legal literacy, provider training, and expanded access to affordable, confidential services. These findings provide evidence for rights-based, intersectional reproductive health interventions targeting marginalized populations in crisis settings.

P 34

Addressing gaps in abortion training: outcomes of a cross-state visiting rotation model

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Background:
Access to safe abortion care depends on the availability of trained clinicians. Following the 2022 Dobbs decision, abortion training opportunities for U.S. trainees have declined substantially, particularly in states with severe restrictions. Many obstetrics and gynecology (Ob/Gyn) residents are unable to meet Accreditation Council for Graduate Medical Education (ACGME) procedural graduation requirements at their home institutions, contributing to workforce gaps and reduced patient access to care.

Objectives:
To evaluate the educational impact of a Complex Family Planning (CFP) visiting rotation on resident procedural experience, confidence, and ability to meet ACGME requirements.

Methods:
We conducted a prospective cohort study at a single academic center offering a four-week elective rotation to visiting Ob/Gyn residents between March 2023 and June 2025. Participants completed pre- and post-rotation surveys assessing procedural volume, clinical experience, and self-reported confidence in abortion care and complication management.

Results:
Twenty-two residents from 10 states participated, with 82% training in states with total abortion bans and 77% reporting no prior abortion training at their home institutions. Before the rotation, 91% had performed zero first-trimester uterine evacuations. After four weeks, 45% had completed more than 20 procedures, meeting ACGME graduation requirements, and an additional 32% had performed 11–20 cases. Similar gains were observed in medication abortion management and options counseling. Confidence improved across all domains, including procedural skills and management of complications. Qualitative feedback emphasized the importance of patient-centered care, pain management, and exposure to full-spectrum reproductive health. Several participants reported increased intention to incorporate abortion care into future practice, and three pursued subspecialty training in Complex Family Planning.

Conclusions:
Short-term visiting rotations can significantly improve abortion training for residents from restrictive states, enhancing competency and confidence. Expanding such programs is critical to maintaining a skilled workforce and ensuring equitable access to reproductive health care.

P 35

Information inequities and safe abortion access: community perspectives from Madhesh Province, Nepal

Information Inequities and Safe Abortion Access: Community Perspectives from Madhesh Province, Nepal Ms Ashana Kumari[1,2,3,4], Ms. Medha Sharma[1], Ms Shilpa Lamichhane[1], Mr. Dipesh Limbu[1], Anand Tamang[3], Aliza Singh[4], Krishna Kumari Waiba[2], Dr. Laxami Tamang[2], Ms Mamta Bista[2], Ms. Shweta Karna[2], Ms Bhagwati Adhikari[2]
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Background:
Although abortion has been legal in Nepal since 2002, persistent gaps in knowledge of abortion laws and reproductive rights continue to limit equitable access to safe abortion services. This study explored community knowledge, perceptions, and information barriers related to safe abortion, with particular attention to findings from Madhesh Province, within a baseline study conducted in Madhesh, Lumbini, and Karnali provinces.

Method:
A qualitative baseline study was conducted under the Kaleidoscope Initiative using focus group discussions with adolescent girls, adolescent boys, married women, married men, and community decision-makers. Discussions explored knowledge of abortion laws, perceptions of abortion, sources of information, and barriers to accessing accurate information and services.

Results:
Findings revealed limited awareness of Nepal's abortion law and legal provisions across study sites, with particularly pronounced information gaps observed among communities in Madhesh Province. Participants reported substantial misconceptions regarding abortion eligibility, service availability, and reproductive rights despite the existence of a supportive legal framework. Persistent stigma, fear of social judgment, and restricted communication about sexual and reproductive health contributed to poor knowledge and delayed care-seeking. Adolescents and unmarried young women faced particular challenges due to limited access to comprehensive sexuality education and youth-friendly information.

Conclusions:
Information inequities remain a significant barrier to safe abortion access in Nepal, particularly within underserved communities in Madhesh Province. Strengthening community-based education initiatives, expanding access to culturally and linguistically appropriate information, and engaging community leaders, health workers, and local stakeholders may improve awareness of legal abortion services and reproductive rights. Addressing misinformation and abortion-related stigma is critical to translating legal rights into meaningful access to safe abortion services and advancing reproductive justice.

P 36

Bridging the training gap: the comprehensive abortion care learning program at the WHO Academy

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Background:
Access to safe, high-quality, and respectful abortion care remains a critical component of universal health coverage and SRH services. However, many countries continue to face shortages of trained providers, largely because pre-service and in-service health professional education often lacks standardized comprehensive abortion care (CAC) content. These workforce gaps contribute to inequitable access to quality abortion services.

Objectives:
To address global training gaps, the Comprehensive Abortion Care Learning Program was developed by the UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP/WHO), in collaboration with the WHO Academy. The objective of the learning program is to equip providers with the competencies needed to deliver evidence-based, quality abortion care.

Methods:
The learning program is grounded in the WHO Abortion Care Guideline and the Family Planning and Comprehensive Abortion Care Competencies Framework. The program is free, self-paced online learning initiative designed for healthcare workers involved in the provision of CAC.

Results:
The learning program is structured into four separate but complementary courses that can be completed independently or as a complete learning pathway. Each course delves into the multifaceted dimensions of CAC, examining it not only as a medical procedure but also as an important element of sexual and reproductive health and rights. Through case studies and practical applications, the learners will engage with real-world scenarios that strengthen their knowledge required to provide evidence-based quality CAC. Participants can access learning materials at any time, receive award of completion, and provide feedback through exit surveys that support continuous program improvement.

Conclusion:
Future priorities include expanding multilingual availability to increase accessibility and global reach, integrating the program into national pre-service and in-service training initiatives. Course content will be regularly updated based on participant feedback, emerging evidence, evolving learning needs, and updated WHO recommendations.

P 37

Co-producing effective training for mental health professionals to improve the sexual and reproductive health of people accessing mental health services: a focus group study

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Background:
People living with mental illness have higher risk of sexually transmitted infections (STIs), HIV, unplanned pregnancies and abortions. These have huge potential physical and mental health sequelae.
Evidence shows mental health (MH) clinicians feel their patients' sexual and reproductive health (SRH) is important; but they lack confidence discussing this and would like training. They develop patient relationships over time, discussing sensitive topics, so could successfully identify those who may benefit from referral to SRH and suggest this to patients. This project asks: what is the best way to train MH professionals to help them know which patients would benefit from SRH care?

Methods:
Ethics approval from UCL. Co-production of training was based on the Kern six-step curriculum development for medical education model. Two recorded workshops were held with seven MH staff from different backgrounds. Workshops identified educational content and strategies. Suggested session plans and learning outcomes were explored with eleven people with lived MH experience. Staff refined materials following PPIE groups.

Results:
Staff said sessions should 'be a basic overview' to 'instil confidence […] to ask the questions but not provide the answer' and prioritise 'communication', 'signposting', and 'being trauma-informed'. PPIE groups said 'context is key'; staff should make 'assessment[s]' based on 'emotional intelligence' and avoid 'medication reviews'. Staff wanted patients to 'feel seen and safe'. Two sessions were designed – on knowledge and communication, following fictional patients in different settings. Staff preferred live sessions with multimedia, including consultation videos.

Conclusion:
Staff wanted SRH communication training and to avoid information overwhelm whilst balancing necessary knowledge to refer to SRH. They wanted examples of starting this conversation in different contexts. PPIE groups felt the project was 'important' and our discussions 'productive'. Materials can be shared.

P 38

Digital platforms for menstrual health: navigating potential and gaps in disorder management

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Background:
Menstrual disorders, including heavy menstrual bleeding, dysmenorrhoea, and polycystic ovarian syndrome, are common affecting more than 500 million women globally and are frequently underdiagnosed, particularly in low- and middle-income countries (LMICs) where access to care is limited. Digital health platforms, including mobile applications, AI-driven chatbots, and symptom trackers, have proliferated rapidly and are increasingly positioned as tools to improve awareness, triage, and access to care for menstrual disorders. However, there is limited evidence on their clinical utility, validity, and suitability for LMIC contexts.

Objectives:
This review aimed to map the landscape of digital platforms addressing menstrual disorders; assess their functional scope, including symptom tracking, triage, and clinical linkage; and identify gaps relevant to detection of menstrual disorders in LMIC settings.

Methods:
We reviewed digital menstrual health platforms identified through play store and app store searches and through published literature between 2021 to 2026. Platforms were assessed against a framework covering clinical validity, scope (tracking versus disorder-specific screening), language, linkages with clinical care and equity focus (affordability, low-literacy design). We compared 6 most commonly used platforms.

Results:
The majority of reviewed platforms focus on fertility and cycle tracking, with few offering validated screening tools for specific disorders such as heavy menstrual bleeding or PMOS. Most are designed for high-resource settings, with limited multilingual support, suitability of educational content for low literacy users and offline functionality. Few platforms link users to a formal referral or care pathway beyond generic advice.

Conclusions:
Digital platforms hold significant potential to improve early recognition and access to care for menstrual disorders, but most current tools are not designed for clinical integration or LMIC deployment. There is a clear opportunity for platforms that combine validated screening tools with educational content and referral advice suited to low resource setting users.

Health Care Professionals

P 39

Advancing sexual and reproductive health and rights of persons with disabilities in Nepal

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Background:
Sexual and reproductive health and rights (SRHR) programs for persons with disabilities (PWD) remain limited in Nepal, despite global commitments to inclusive, rights-based health services. PWD face multiple barriers, including social stigma, lack of information, and physical or communication challenges when accessing SRHR services. To address these gaps, the Family Planning Association of Nepal (FPAN), with support from Väestöliitto – the Family Federation of Finland, implemented the project *"Advancing Sexual and Reproductive Health and Rights of Persons with Disabilities in Nepal"* from 2019 to 2025 in Kathmandu, Lalitpur, Bhaktapur, and Banke. The project aimed to enhance PWD knowledge, community awareness, civil society engagement, and advocacy, contributing to SDG targets 3.7 and 5.6.

Methods:
An end-line evaluation by the Policy, Evaluation and Health Research Centre (PEHRC) employed a mixed-methods approach. Qualitative data included four focus group discussions with PWD and peer educators, and 12 in-depth interviews with FPAN staff, service providers, government representatives, and partners. Quantitative data were collected from 101 PWD (51 in Kathmandu Valley, 50 in Banke) using structured questionnaires on demographics, SRHR knowledge, service utilization, and project participation.

Objectives:
High engagement was observed: 92% of PWD participated in FPAN programs, and 88% received life-skills-based peer education. Awareness of family planning was high, with 78% visiting FPAN clinics. Participants reported increased confidence in discussing sexuality and reproductive health, improved SRHR knowledge, and greater openness regarding family planning, menstruation, and gender-based violence. The project reduced stigma and enhanced communication between PWD, families, and providers.

Conclusion:
The project empowered PWD by improving SRHR access, knowledge, and confidence while reducing stigma. Peer educators and civil society engagement strengthened inclusivity. Expanding coverage, skill-based training, and government support remain challenges. Scaling up inclusive SRHR models can ensure sustainable, equitable access for PWD across Nepal.

P 40

Beyond law: the role of intermediary actors in access to abortion care and information in Tunisia

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Background:
Access to healthcare is not determined solely by laws and policies, but also by the practices of intermediary actors such as administrative staff and frontline workers. These individuals often serve as the first point of contact and play a decisive role in shaping patients' experiences and care trajectories. Their influence becomes especially significant in the context of abortion care, where they frequently act as informal gatekeepers, either facilitating or obstructing access to timely, accurate, and judgment-free services.

Objectives:
Abortion has been legal in Tunisia since 1973, permitted on request until 12 weeks. This study examines how frontline workers in abortion and family planning clinics influence access to abortion information and services. It draws on a qualitative analysis of simulated phone interactions with staff at 60 facilities, comprising 21 public family planning centers and 39 private clinics, spanning across 21 governates of Tunisia.

Conclusion:
Findings reveal that while many agents offered medically structured guidance, such as gestational age confirmation and referral, others imposed additional hurdles through administrative requirements or moralizing responses, particularly toward unmarried women. These interactions highlight how abortion access can be influenced by intermediary actors in the healthcare system and underscore the need to professionalize and standardize these practices to ensure equitable, stigma-free access to abortion care.

P 41

Strengthening provider confidence and reducing stigma: a capacity-building model to improve safe abortion service delivery in Lagos, Nigeria

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Background:
Healthcare providers are essential to safe abortion access, yet in restrictive settings like Nigeria, their ability to deliver services is limited by legal ambiguity, stigma, and inadequate training. Baseline findings from IRISE project activity in Oshod-Isolo LGA, Lagos State indicated persistent gaps in legal knowledge, confidence, and service readiness among providers.
Objectives:
To evaluate the effect of a structured capacity-building intervention on provider knowledge, confidence, stigma, and readiness to deliver safe abortion services.

Methods:
Between September 2024 and July 2025, a provider-focused intervention was implemented in Oshodi-Isolo LGA. Forty providers were mapped, and 22 participated in a needs assessment. Fifty-six providers (nurses, midwives, pharmacists, and community practitioners) were trained through a two-day intensive programme covering clinical guidelines, legal frameworks, trauma-informed counselling, and self-care. Peer support networks were also established. Pre- and post-training assessments measured changes in knowledge, confidence, and perceived barriers.

Results:
Baseline findings highlighted stigma, legal uncertainty, and inconsistent access to supplies as major constraints. Post-intervention, provider knowledge and confidence increased by 92%. Participants reported greater willingness to provide counselling and referrals. Peer networks reduced professional isolation and improved collaboration. However, systemic gaps such as supply chain limitations and the need for continuous training remained. Providers identified internalized stigma as a persistent but addressable barrier.

Conclusions:
Structured training combined with peer support significantly improves provider readiness and confidence in delivering safe abortion care. Sustained capacity-building, legal clarity, and stigma-sensitive approaches are critical to strengthening service delivery systems in restrictive environments.

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Healthcare providers' perspectives on barriers to safe abortion services in Madhesh Province, Nepal

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Background:
This study assessed barriers to legal, safe, and free abortion services (SAS) at public health facilities in Madhesh Province, Nepal, from the perspectives of health care providers. Facility assessments of 39 SAS-accredited facilities and key informant interviews revealed gaps in infrastructure, supplies, human resources, and service visibility. While hospitals and PHCCs generally had counseling rooms, waiting areas, and examination rooms, several health posts lacked separate spaces, and one health post in Malangwa was in dilapidated condition. Only a few facilities displayed accreditation certificates or maintained consistent service information in citizen charters.

Objectives:
Service provision was affected by shortages of trained staff, delayed appointments, and missing certifications. Seven facilities had stopped providing SAS due to the absence of trained providers or administrative barriers. Supply challenges included irregular availability of medical abortion (MA) drugs; half of the facilities lacked stocks due to delayed reimbursements or procurement issues. Clients preferred MA over MVA due to convenience,

simplicity, and privacy concerns. One provider explained, “Most prefer MA because many women are afraid of undergoing a surgical procedure. Since MA is easier, just like simply taking medicine, they tend to choose MA.” Data reporting systems were inconsistent, with some facilities maintaining electronic and hard copy reporting.

Methods:
Recommendations include strengthening coordination among federal, provincial, and local governments to ensure at least one SAS facility per municipality offering MA, and 1–2 PHCCs/hospitals providing MVA. In-service training for new SAS providers should be prioritized with periodic appraisal by Provincial Health Training Centers (PHTC). Routine M&E visits should monitor drug availability, provider presence, and service visibility. The provincial training package should update curricula, integrate VCAT modules, conduct refresher trainings, ensure IEC materials, and expand the pool of trainers.

Conclusion:
A provincial platform should coordinate training, provider placement, and supervision, with systems to track staff transfers and service availability.

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Quality of care and their association with client satisfaction and peer referral intent among adolescent girls and young women (15–29 Years) accessing SRHR services in Uganda

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Background:
Adolescent girls and young women (AGYW) in Uganda face a disproportionate SRH burden including high teenage pregnancy rates, and significant SGBV exposure, compounded by stigma, provider attitudinal barriers, and inadequate privacy infrastructure. To address this, Stand Up for SRHR project deploys an improvement strategy in selected health facilities across seven districts in Uganda.

Objective:
To analyze improvements in facility-level quality of care (QOC) compliance and describe observed trends in client satisfaction and peer referral intent among AGYW, draw programmatic inferences about their association with QOC gains across two indicators - contraceptive availability and gender-responsive SRH service provision.

Method:
Retrospective review of project monitoring data. QOC assessments tracked two indicators: modern contraceptive availability (including ≥1 LARC) and gender-responsive SRH service provision. Client exit interviews with AGYW aged 15–29 assessed satisfaction across eight service domains via a five-point Likert scale, with peer referral intent measured using NPS methodology. Findings are descriptive, with associations inferred from observed trends.

Results:
By year 5, QOC assessment coverage reached 100% compared to year 3 (73%), with overall compliance to the 2 indicators improving from 75% (year 3) to 94% (year 5), a 19 percentage-point gain as contraceptive availability reached 96% and gender-responsive service provision reached 92%. Client satisfaction exceeded 90% combined 'Satisfied' and 'Very Satisfied' responses for provider friendliness, confidentiality and privacy domains in all age cohorts. NPS improved across all cohorts: adolescent girls (15–19 years) from 51.2 to 59.1 (+7.9pp); young women aged 20–24 from 40.3 to 63.4 (+23.2pp); and young women aged 25–29 from 44.1 to 61.1 (+16.9pp). Aggregate NPS rose by 16.0 percentage points, consistent with observed QOC compliance trajectory.

Conclusions:
Findings demonstrate that systematic QOC improvements spanning provider competency strengthening, and coordinated performance review, generated gains in service quality and client satisfaction among AGYW aged 15–29 years.

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Bridging law and access: female community health volunteers and safe abortion in Madhesh Province, Nepal

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Background:
Although abortion has been legal in Nepal since 2002, women in many communities continue to face barriers to accessing safe abortion services. Female Community Health Volunteers (FCHVs), as trusted frontline health workers, play a critical role in connecting women with reproductive health services, yet little is known about how their knowledge, attitudes, and practices influence abortion access.

Objectives:
To explore FCHVs' perceptions of abortion, their role in facilitating access to safe abortion services, and opportunities to strengthen community-based referral and support systems in Madhesh Province, Nepal.

Methods:
Qualitative focus group discussions were conducted with FCHVs in selected districts of Madhesh Province as part of a baseline assessment under the Kaleidoscope Collective. Discussions explored abortion-related knowledge, community interactions, referral practices, perceived barriers, and recommendations for improving access. Data were analyzed thematically.

Results:
FCHVs occupied a pivotal but complex position between communities and the formal health system. While some viewed abortion as an essential reproductive health service and referred women to certified providers, others associated abortion with sin, infertility, or serious health consequences, reflecting persistent misconceptions. Married women

occasionally sought advice, often indirectly by reporting missed menstruation, whereas adolescents rarely approached FCHVs because of stigma and concerns about confidentiality. Participants reported that abortion is seldom discussed during routine FCHV meetings and many described limited training on abortion law, medical abortion, and referral pathways. FCHVs recommended dedicated abortion education sessions, values clarification training, stronger confidentiality safeguards, greater engagement of men and older family members, expanded community awareness, and improved local availability of safe abortion services.

Conclusions:
Legal reform alone does not ensure equitable abortion access. Strengthening the knowledge, confidence, and referral capacity of FCHVs offers a practical opportunity to bridge the gap between legal rights and lived access to safe abortion in underserved communities.

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Changing the first point of contact: a national training initiative for doctors and pharmacists to improve safe abortion access in Nepal

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Background:
Nepal legalized abortion in 2002 and expanded the law in 2018, but many rural women lack access to timely, respectful care. Barriers include provider stigma, limited knowledge of abortion law and services, and weak referral networks.

Objectives:
To evaluate the effectiveness of a nationwide training programme designed to improve abortion provider knowledge, reduce stigma, strengthen referral pathways, and enhance access to respectful abortion care.

Methods:
Twenty-one doctors (three per province) were trained as provincial trainers who subsequently led Safe Choice workshops and mentored colleagues. A total of 470 pharmacists from 56 districts participated in sessions on abortion law, medical abortion, values clarification (VCAT), respectful counselling and referral. Provider knowledge was assessed by pre- and post-training tests. Referral rates (from facilities without abortion services) were calculated from registers by comparing six months before and after training. Standardized mystery client visits used a structured Medical Abortion Counselling and Instruction Score (MACIS) to assess provider communication, the accuracy of medical abortion instructions (drug regimen, administration, expected effects, warning signs, follow-up) and referral practices.

Results:
The program established a network of trained providers across all provinces. Post-training knowledge improved in 97% of doctors and 93% of pharmacists ($p<0.001$). Referrals from trained health workers increased by 37% (95% CI: 28–46%; $p<0.01$), indicating better linkages to authorized services. Mystery client assessments showed that the proportion of pharmacists providing satisfactory medical abortion counselling (per MACIS) rose from 42% before training to 81% after training. Trained providers also demonstrated more respectful, non-judgmental communication and appropriate referral practices.

Conclusions:
Supportive law alone is not enough to ensure safe abortion access. Training and connecting doctors and pharmacists improved provider knowledge, attitudes, and referral systems, leading to more timely, stigma-free care. This practical model may help expand access to safe abortion services in other low-resource settings.

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How can community mental health professionals better support their patients' sexual and reproductive health? a focus group study

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Background:
The sexual and reproductive health (SRH) inequalities faced by people living with mental illness is well-documented; this patient group has higher risk of sexually transmitted infections, unplanned pregnancies, abortion and worse maternal/fetal outcomes. Mental health (MH) professionals believe their patients' SRH is important but don't raise it due to under-confidence and training gaps. Community teams build long-term relationships and are well-placed to start SRH conversations. This study aimed to explore the role of UK community-based MH professionals in supporting their patients' SRH, barriers to this and asked how they could be supported to enact this role.

Methods:
Ethics approval was obtained. Participants recruited via personal networks and snowballing. Two online focus groups were held in with NHS community mental health team (CMHT) professionals. Focus groups were transcribed anonymously and analysed using thematic analysis.

Results:
Group one contained six non-doctor CMHT professionals from one service who were all women of colour. Group two contained eight psychiatry doctors of differing seniority, ethnicities and genders from various teams. Five themes identified: SRH is not routinely discussed by MH professionals; easier to discuss when medicalised; professionals believe SRH care is important but struggle with moral injury when referring; professionals are more likely to support patients' SRH if the relevance to their patients is clear; training should focus on relevance.

Conclusions:
The themes reflect those in the literature. The novel finding is the need for MH professionals to understand the relevance of SRH to their patients. They identified unmet educational needs – basics of SRH and worse SRH health outcomes for their patients. Professionals felt they must understand the 'why' to improve confidence and to reassure patients they're discussing SRH to improve health. This would help mitigate barriers including clinician-patient power dynamics and differing cultural backgrounds of staff/patients. Professionals requested training - in development.

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Unintended pregnancy care: experiences and needs of general practitioners and midwives

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Background:
Reproductive healthcare in the Netherlands has changed considerably in recent decades, particularly regarding care for people experiencing unintended pregnancies. These developments directly influence general practitioners (GPs) and midwives, who play a central role in reproductive healthcare. However, little is known about their experiences in providing this care.

Objectives:
To explore the experiences and perceived needs of Dutch GPs and midwives when providing care for people experiencing unintended pregnancies.

Methods:
This qualitative study included 17 primary care professionals in the Netherlands: eight GPs and nine primary care midwives. Semi-structured interviews were conducted in 2023 and 2024. Participants reflected on clinical cases and general aspects of unintended pregnancy care. Interviews were transcribed and analysed thematically using an iterative approach.

Results:
Three overarching categories emerged: (1) systemic barriers and facilitators, (2) personal barriers and facilitators, and (3) perceived competence.
Systemic challenges included limited interprofessional collaboration, time constraints, lack of reimbursement (particularly for midwives), and accessibility barriers. Participants highlighted distance to abortion clinics, stigma, limited follow-up care, and fragmented referral pathways.
Counselling was shaped by professionals' beliefs, experiences, and communication styles. While most aimed to provide open, non-judgemental, and patient-centred care, personal biases and values could influence counselling. Facilitators included taking time, asking open-ended questions, and avoiding directive counselling.
Many participants reported limited training and unclear guidelines, leading to uncertainty about their role, particularly regarding aftercare. Perceived competence related to both communication skills and medical knowledge, and many participants expressed a need for additional training and resources.

Conclusions:
Dutch GPs and midwives strive to provide open, non-judgemental, patient-centred care for people experiencing unintended pregnancies, but their ability to do so is shaped by personal, professional, and systemic factors. Improving care may be achieved by increasing awareness and use of existing resources, strengthening training, and developing collaboration pathways.

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Building sustainable healthcare provider skills and competency for delivery of long-acting reversible contraceptives: lessons from a structured clinical mentorship model in Uganda

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Background:
In Uganda, translating healthcare provider training into sustained clinical competency remains a challenge, constrained by inadequate post-training support, provider hesitance particularly toward intrauterine device (IUD) insertion, driven by bias and negative attitudes, and the compounding effect of skilled provider attrition. In resource-limited settings, standalone training interventions consistently demonstrate limited efficacy in sustaining clinical proficiency and therefore inadequate service delivery.

Objective:
To strengthen healthcare provider competencies for LARC delivery; and demonstrate the association between improved provider competency through structured clinical mentorship and LARC service delivery volumes at supported health facilities.

Method:
Structured clinical mentorship program was implemented across six successive cohorts, each comprising 48 mentees paired with mentors at a 1:2 ratio. Mentorship targeted provider competency and clinical skills across LARC delivery, client-centred counselling, PAC, and cervical cancer screening. Competency was assessed over six months against defined minimum targets, with specific focus on implant and IUD uptake.

Results:
Pre-mentorship baseline (October 2022 – March 2023) recorded 3,963 implant and 143 IUD insertions. Implant uptake rose 68.9% to 6,692 in Cohort 1, peaked at 7,499 in Cohort 4, and remained above baseline across all six periods, including the lowest post-mentorship volume of 4,628 (Cohort 3), which still exceeded baseline by 16.8%. IUD insertions exceeded baseline in every period, rising from 143 to 1,503 in Cohort 1 and recovering to 1,312 in the final period following a mid-program decline attributable to stock-outs and provider skills gaps.

Conclusion:
These findings demonstrate that structured clinical mentorship delivers measurable, sustained improvements in provider competency and LARC service delivery for AGYW in resource-limited settings. The progressive transition of mentees to mentors builds an internally generated expert pool, reinforcing long-term sustainability and offering a replicable, scalable framework for closing the persistent gap between training and practice.

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Authorised but underused: the gap between legal accessibility and real-world clinical practice of medical abortion through teleconsultation in France

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Background:
In France, teleabortion, temporarily introduced during COVID, was made permanent in 2022. Yet, its practice remains marginal (1,587 of 201,000 medical abortions in 2024), with limited data on adoption among practitioners.

Objectives:
This study quantifies teleabortion practice among community-based professionals in France, and characterises barriers specific to remote versus in-person care.

Methods:
An online survey was conducted in April 2026 among 225 professionals performing medical abortions outside healthcare facilities in France (75 GPs, 75 gynaecologists and 75 midwives). The sample enabled cross-speciality comparison. The survey covered abortion volumes, protocols, teleabortion practices, and perceived difficulties. Descriptive statistics were performed by speciality with significance testing at 95% confidence level.

Results:
Only 14% of HPs use teleabortions (midwives: 27%, GPs: 12% and gynaecologists: 4%), with low monthly volumes (GPs: 7, gynaecologists: 2, midwives: 1). Overall difficulties remain comparable (74% remote vs 75% in-person), but their nature differed. Teleabortion-specific obstacles were medication dispensation (44% vs 15%), ultrasound access (38%) and technical issues (31%). Furthermore, scheduling appointments (30%), patient apprehension (20%) and information exchange with the patient (15%) were cited in-person care and not in teleabortion. Managing complications was more cited in face-to-face (35%) than in remote care (19%). Key informations required re-explanation in one in four consultations. Perceptual barriers persist preference for face-to-face consultation (32%), direct medication dispensing (21%), misuse (17%) and concerns about pharmacies (12%).

Conclusions:
Despite a favourable legal framework, teleabortion adoption reflects distinct professional cultures across specialities. Barriers are logistical and perceptual rather than medical or regulatory. However, frequent re-explanation in face-to-face consultation, fear of misuse and mistrust of pharmacies reinforce HPs attachment to in-person care. France could draw inspiration from other EU model by developing appropriate operational and educational resources for quality remote support.

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Medical abortion workforce and provider characteristics: a cross-sectional study from Victoria, Australia

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Background:
Medical abortion (MA) is projected to become the most common abortion method in Australia, mirroring global trends. However, access remains inequitable. MA provider numbers remain limited, particularly in rural and regional areas, constraining access and choice. As of June 2023, only 17% of general practitioners in Victoria, Australia provided MA. Recent regulatory changes have expanded MA prescribing to nurse practitioners, endorsed midwives, and nurse prescribers, signalling a shift in abortion care, but there is limited data on MA provider characteristics or the barriers they encounter.

Objective:
To inform strategies to sustain and expand the MA workforce, we explored the sociodemographic and professional characteristics of MA providers in Victoria, Australia.

Methods:
We conducted a cross-sectional descriptive analysis of MA providers in Victoria who were registered and publicly listed on the 1800 My Options provider directory, a state-wide sexual and reproductive health information and referral service, with a recruitment goal of 400 providers. We cross-referenced provider names with Australian Health Practitioner Regulation Agency profiles to collect geographic location, sex, professional qualifications, languages spoken other than English, and country and year of initial qualification. Descriptive statistics and narrative synthesis were used to analyse and summarise the data.

Results:
Preliminary findings suggest that most registered, publicly listed providers are female (75%, 91/122) and based in metropolitan areas (80%, 97/122). Providers who completed their primary clinical qualification in Australia or overseas are approximately equal (53%, 64/122 vs 47%, 58/122), while half speak a language other than English (51%, 62/122). Final analyses will be presented.

Conclusion:
This study is the first phase of a broader project examining individual and system factors that support or constrain MA provision in Victoria. Findings will inform workforce planning and approaches to improve provider recruitment, retention, and support, enhancing equitable MA access across Australia.

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Exploring Dutch abortion care providers' perspectives on expanding medical abortion provision beyond specialized clinics: insights for the future of abortion care

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Background:
After decades of being mainly provided by specialized clinics, medical abortion provision in the Netherlands has recently been extended to general practice and an online telemedicine abortion service. However, these providers operate through distinct care pathways with limited alignment in clinical practice. The perspectives of Dutch Specialized Abortion Providers (DSAPs) on these developments have not yet been studied. Understanding these perspectives is essential to understand how abortion care can evolve while maintaining a high-quality abortion care landscape.

Objectives:
To explore the perspectives of DSAPs on the changing Dutch abortion care landscape following the expansion of medical abortion provision to new providers and to identify conditions for the sustainable development of this landscape in high-resource settings.

Methods:
Data were collected between April and June 2026. Ten semi-structured individual and group interviews were conducted with sixteen DSAPs (physicians, nurses and board members) from four Dutch abortion clinics. Data were analysed using inductive thematic analysis in NVivo.

Results:
Overall, participants expressed positive attitudes towards the expansion of medical abortion provision to new providers, as it was perceived to contribute to the mainstreaming of abortion care and stimulate care innovation. Main concerns centered on differing views of high-quality abortion care among providers and the rigid financing system of Dutch abortion clinics, which was perceived to be a barrier to adapting to the changing care landscape. Three structural challenges underpinned these concerns: care fragmentation, contested evidence and knowledge among care providers, and limited professional recognition of abortion care. Addressing these challenges was considered essential for the sustainable development of the Dutch abortion care landscape.
Conclusions: Moving abortion care beyond its historical separation requires addressing structural challenges and strengthening interdisciplinary collaboration to achieve a high-quality and sustainable abortion care landscape.

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Sustainability of comprehensive abortion care and post-abortion care in Cameroonian health systems

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Background:
In Cameroon, unsafe abortion causes many maternal deaths and serious health problems. Comprehensive abortion care (CAC) and post-abortion care (PAC) can reduce these deaths, but services often depend on short-term projects and are not part of regular health systems.

Objectives:
To identify factors that help or hurt the long-term success of CAC and PAC services in Cameroon's health system and develop a framework for "deep sustainability."

Methods:
Mixed-methods study in four regions with high abortion problems. Target population: health managers, providers, community accompaniers, donors. Sample size: 54 facilities (quantitative), 35 interviews (qualitative). Sampling technique: purposive for facilities with CAC/PAC services; snowball for key informants. Data collection: facility assessments (service availability, methods, staffing, funding), semi-structured interviews. Analysis: descriptive statistics for quantitative data; thematic analysis using health systems framework (governance, financing, workforce, service delivery, information, commodities) for qualitative data. Ethical considerations: informed consent, anonymisation, facility permission. Inclusion: facilities offering CAC/PAC, knowledgeable informants; exclusion: non-SRH facilities, uninformed respondents.

Results:
Quantitative themes: Only 28% of facilities offered WHO-recommended methods (manual vacuum aspiration, medical abortion); 62% used dilation and curettage. 71% funding was external projects; 12% government-funded.
Qualitative themes (health systems lens):
Financing vulnerability: Short-term donor dependence, abortion stigma blocked budgets.
Service delivery gaps: Political de-prioritisation reduced supervision.
Workforce resilience: Facilities with community links and staff training continued services during shocks.
Success factors: Integration into maternal health packages sustained services.
Deep sustainability framework: diversified funding, institutional norms, community accountability.

Conclusions:
CAC/PAC sustainability requires political support, local funding, and community partnerships beyond project models. The deep sustainability framework guides durable access in fragile systems.

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From stigma to service uptake: a community-driven model to strengthen safe abortion access in Lagos, Nigeria

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Background:
Unsafe abortion remains a leading contributor to maternal morbidity and mortality in Nigeria, driven by stigma, limited awareness of safe options, and weak service linkages. Baseline findings in Lagos State showed low awareness of safe abortion services (45%) and high levels of stigma (55%). The Pamoja Project led by IRISE was designed to address these barriers through an integrated community, provider, and systems-strengthening approach.

Objectives:
To assess the impact of a multi-component intervention on abortion-related awareness, stigma reduction, provider readiness, and service linkage.

Methods:
A mixed-methods intervention was implemented between September 2024 and July 2025 in Oshodi-Isolo Local Government Area, Lagos, Nigeria. Activities included stakeholder mapping, key informant interviews (n>100), provider assessments (n=22), training of 56 healthcare providers, and community outreach reaching over 1,200 individuals. Additional components included engagement with 20+ policymakers, deployment of a confidential SAFE VOICE helpline, and collaboration with five digital influencers reaching over 60,000 people. Routine monitoring assessed changes in awareness, stigma, provider competence, and referrals.

Results:
A post-intervention data showed a 60% increase in awareness of safe abortion options and measurable reductions in stigma. Provider knowledge and confidence improved by 92% following training. Increased uptake of counselling and referrals was recorded through outreach and the helpline. Strengthened provider networks and referral pathways were established, alongside renewed stakeholder commitment toward reinstating the Safe Termination of Pregnancy (STOP) guideline.

Conclusions:
Integrated community engagement, provider strengthening, and digital advocacy significantly improved awareness, reduced stigma, and enhanced service linkage. The Pamoja model demonstrates a scalable approach for improving safe abortion access in high-stigma, restrictive contexts.

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Imagining a better future for abortion care: a feminist framework for policy and practice

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Background:
Abortion access is often understood primarily in terms of legality and service availability, overlooking broader power structures that shape abortion experiences. Abortion care continues to be constrained by entrenched inequalities, stigma, and regulatory exceptionalism, even in legally liberal settings. Decriminalisation alone does not guarantee access: structural barriers - cost, geography, institutional gatekeeping, discriminatory norms, rights rollbacks - continue to impede reproductive autonomy. Considering key elements of varied approaches to abortion offers important lessons for sustainable, community-embedded care. Achieving genuinely person-centred, equitable abortion care requires a feminist framework attuned to intersecting social, legal and institutional dynamics.

Objectives:
To establish key components of a feminist abortion framework centring the needs of abortion seekers, particularly those most marginalised, by a) defining what constitutes a 'feminist abortion', grounded in person-centred care and reproductive justice; b) articulating the SISSDAA principles as a framework for evaluating and improving abortion care with international relevance; c) illustrating their application across one 'case study' jurisdiction (Scotland).

Method:
To develop this framework, we drew on interdisciplinary feminist scholarship, reproductive justice theory, and a range of empirical research from multiple global contexts.

Results:
We propose seven core principles - Supported, Informed, Safe, Stigma-free, Decriminalized, Autonomous, Accessible (SISSDAA) - as a means of guiding abortion practice, policy and research. This framework highlights the need to: mainstream abortion care; ensure culturally safe, inclusive services; and advocate for policy environments that support diverse, flexible care models.

Conclusions:
The SISSDAA framework provides a powerful tool to evaluate and redesign abortion care in ambitious ways which think beyond immediate medico-legal constraints. Embedding these principles has potential to strengthen person-centred practice by addressing the structural inequities which undermine reproductive autonomy. The framework offers a benchmark for clinicians, policymakers, activists, and researchers to assess current practices and envision more equitable and inclusive models of abortion care.

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Engineering fear, delivering Care: how digital reproductive health models bypass anti-rights rhetoric in Georgia

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Background:
Georgia has experienced a rollback of sexual and reproductive health and rights (SRHR), driven by restrictive regulations and coordinated anti-rights digital rhetoric. While abortion remains legal within 12 weeks, regulatory obstacles contradict WHO safety guidelines. These barriers create acute geographic and financial hurdles, particularly disadvantaging underserved rural populations facing systemic healthcare inequities.

Objectives:
This study examines the systematic framing of anti-rights narratives across digital channels in Georgia and investigates how hostile rhetoric drives institutional hesitation. Furthermore, it evaluates alternative digital health models in countering online stigma, misinformation, and structural barriers to safely reconnect underserved populations with evidence-based medical care.

Methods:
A dual-methodological framework combined AI-facilitated narrative analytics with a case study of Association HERAXXI's digital service model. Utilizing an AI-powered analytic sweep and social listening across Facebook,Instagram,TikTok,YouTube,X,Telegram,and websites, the study parsed text to track engagement, map sentiment, and cluster dominant anti-rights themes.

Results:
Analysis of 350,000 digital discussions (2024–2026 Q1) yielded core findings:
argeting Demographics: Hostile narratives disproportionately target youth and women. Reproductive rights constitute 12% of women's rights conversations, associating healthcare with moral failure, social exclusion, and crime.
Macro-Narrative Distribution: 90% of digital discourse surrounding women's rights is explicitly saturated by hostile frameworks, including religious manipulation, deep stigma, and targeted disinformation.
Institutional Hesitation: This toxic environment induces severe institutional hesitation, causing healthcare providers to self-censor and hide information regarding legal services out of fear of digital backlash.
Conversely, HERAXXI's digital counseling model operates as a resilient alternative pathway, providing confidential support that bypasses public hostility and breaks this engineered information deficit.

Conclusions:
Anti-human rights groups strategically use social media to engineer environments of fear, shame, and misinformation regarding abortion. Integrated digital health models serve as vital mechanism to bypass physical and social blockades, delivering safe, dignified, and evidence-based care.

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Breaking Through Systems to Reach Those Left Behind: The CATALYTIC Fund's Flexible Grantmaking for Abortion Access in East Africa

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Background:
In East Africa, restrictive legal environments, deep-seated stigma, and entrenched social norms create compounding barriers to abortion access, barriers that fall hardest on people with disabilities, LGBTIQ+ communities, ethnic minorities, and young people. Despite growing recognition of these inequities, conventional funding mechanisms frequently exclude the grassroots civil society actors best positioned to address them. CATALYSTS, an Africa-led coalition advancing abortion rights across the continent identified this gap as both a systems failure and a strategic opportunity.

Objectives:
This presentation documents the design, implementation, and outcomes of the CATALYTIC Fund, which set out to test whether flexible, trust-based sub-granting to local CSOs could generate meaningful norm and policy change for abortion access among underserved populations in Kenya, Uganda, and Tanzania.

Methods:
Through an open Expression of Interest process, CATALYSTS selected 22 CSOs and collectives working on shifting harmful social norms and amplifying pro-abortion narratives. Sub-grants of $10,000–$15,000 were awarded to youth-led, women-led, and community-rooted groups, including organisations and grantees were assessed on innovation, intersectionality, and reach into underserved communities.

Results:
The 22 funded initiatives employed diverse methodologies; legal advocacy, digital storytelling, cultural arts, and community dialogue to reach people with disabilities, LGBTIQ+ persons, ethnic minorities, and adolescents. Grantees reported measurable shifts in community narratives and policy engagement at local and national levels. The fund also demonstrated that flexible, rapid-disbursement mechanisms are operationally viable within institutional consortium structures, challenging assumptions about what responsible grantmaking requires.

Conclusions:
The CATALYTIC Fund demonstrates that breaking through conventional philanthropic systems is necessary to reach most marginalised in the abortion access landscape. Trust-based, flexible funding directed at local CSOs produces innovation, community resonance, and accountability that larger, more rigid grants rarely achieve. This model offers a replicable framework for funders and coalitions seeking to close the equity gap in abortion access across Africa.

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A comprehesive AI-driven abortion consultation chatbot delivered through WhatsApp: Design and Clinical Validation

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Background:
Access to safe abortion services in South Africa remains constrained inequities in healthcare access, despite a supportive legal framework, and up to half of abortions occur outside the formal healthcare sector.

Objectives:
This project aims to develop and evaluate AI for your abortion (AYA) , an artificial intelligence (AI)-driven abortion consultation chatbot delivered through WhatsApp, designed specifically for the South African context.

Methods:
AYA has been built using a Retrieval-Augmented Generation (RAG) architecture that restricts AI outputs to validated clinical sources, including World Health Organization guidelines, South African abortion protocols, and national pharmaceutical regulations. The chatbot conducts comprehensive abortion consultations by confirming user intent and autonomy, assessing eligibility for home medical abortion, estimating gestational age, identifying potential risk factors, and generating structured consultation summaries and eligibility certifications. A novel composite confidence scoring system combines measures of input quality, medical certainty, and model confidence to determine whether recommendations can be delivered autonomously or require human review.

Results:
Our pilot study is being conducted at two public primary healthcare facilities in the Western Cape, South Africa among 70 end-users. AI-generated assessments are compared with blinded in-person clinical consultations and ultrasound findings to evaluate diagnostic accuracy, safety, and escalation decisions. User experience, acceptability, satisfaction, and system usability are being assessed through standardized measures and qualitative interviews. Data will be available by September 2026.

Conclusion:
This study will generate the first prospective clinical validation data for an AI-driven abortion consultation system in sub-Saharan Africa. The findings will inform the safe integration of generative AI into abortion services and provide a scalable model for equitable access to abortion and other reproductive health services in low-resource settings.

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Breaking barriers to abortion access: how the civil society challenges stigma and institutional resistance in Poland

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Background:
Poland has one of the most restrictive abortion legal frameworks in Europe. The stringent law interacts with abortion stigma, anti-abortion mobilisation, and a chilling effect among healthcare professionals. Consequently, lawful abortion may remain inaccessible in practice, and patients may be denied care even when statutory grounds are met. Access narrowed further after the Constitutional Tribunal eliminated fetal impairment as an independent legal ground for abortion.

Objectives:
This presentation examines how civil society resists barriers to abortion access in Poland. Rooted in the sociology of medicine, it analyses how law, medical institutions, professional authority, stigma shape access, and how civil society challenges them through legal advocacy, patient support, professional education, and public communication.
The analysis focuses on strategies developed by the Polish Foundation for Women and Family Planning FEDERA. It draws on law and policy, organisational documentation, case-based advocacy, barriers reported by patients and healthcare professionals, and practitioner knowledge gained through involvement in FEDERA's work.

Methods:
Four key areas are considered: interpretation of legal grounds, development of referral and support networks, patient-centred assistance, and education of healthcare providers. One strategy has been to advance recognition that threats to a pregnant person's life or health include threats to mental health, and to support access to psychiatric assessment and documentation.

Results:
FEDERA assists people navigating refusals, delays, misinformation, and institutional barriers, which disproportionately affect those with fewer financial, geographical, informational, or social resources. Individual support is combined with strategic intervention in cases exposing failures. Training for medical students addresses contraception, abortion care standards, legislation, clinical responsibilities, and stigma-free communication.

Conclusion:
The case shows that abortion access depends not only on formal law, but also on legal interpretation, institutional practice, professional confidence, referral pathways, resources, and social position. It demonstrates how grassroots civil society action can transform limited legal entitlements into access.

P 59

Mystery client methodologies to evaluate abortion care and access: a scoping review

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Background:
Mis, dis and lack of information about abortion impedes access. Mystery shopping designs are well suited to evaluating the availability, accuracy, and quality of health services. However, we lack understanding of their use in abortion research.

Objective:
To synthesize evidence on mystery shopping methods in abortion research internationally.

Methods:
We followed the JBI methodology for scoping reviews and engaged the expertise of a clinical research librarian. We included all English or French language studies of abortion using mystery shopping methods (phone, in person, or other). We did not limit the search by date range or jurisdiction.

Results:
We included 40 studies in our review, published between 2006 and 2025. Settings included 13 countries: USA (13), India (5), Canada (3), Mexico (3), Turkey (3), Bangladesh (2), Colombia (2), Ghana (2), Indonesia (2), and one each in Kenya, Nepal, Tanzania, Zambia and Latin America. Methods included calls (20), in-person visits (18), texts/online messages (3), and combinations of mystery shopping with interview/surveys (7) and systematic online searching (2). Themes included service availability and information quality, with 7 sub-themes, which we mapped to elements of the Levesque framework of patient-centred access: Approachability; Acceptability; Availability and accommodation; Affordability; and Appropriateness.

Conclusions:
Where abortion is decriminalized, efforts to improve abortion can prioritize Levesque concepts, such as ensuring care is affordable, culturally safe, and geographically proximal. Mystery shopping can proxy patient experience and be used as a validity check, such as comparing health professionals' self-reported practice with that experienced by mystery shoppers.

P 60

Adapting digital solutions for abortion remote support in a changing digital environment

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Objectives:
This qualitative study examined the experiences of people seeking and obtaining medication abortion in Canada, focusing on information and support needs, the role of AI and social media, affordability, and access to timely care. We also aim to identify disparities in the experience of racialized abortion seekers compared to white/European participants, in order to inform the Canadian adaptation of Aya Contigo, a digital companion for abortion care.

Methods:
Vitala Global conducted 12 in-depth interviews with people who had undergone a medication abortion between 2021 and 2026. Participants self-identified as women or non-binary, were aged 26–33, and were located across Ontario, Alberta, British Columbia, and Manitoba. Interviews followed a five-part guide covering navigation experience, the medication abortion itself, technology use, and feedback on a Canada-adapted Aya Contigo prototype.

Results:
Racialized participants more often reported difficulty navigating the healthcare system, negative provider interactions, mistrust, stigma-related fear, and a lack of culturally appropriate care; white/European participants generally described more straightforward access and lower stigma concerns. Across all participants, emotional support (reassurance, empathy, privacy, and non-judgment) was consistently identified as a key need. Conversational and AI-based engagement was preferred over static information sources; peer experiences were especially reassuring. AI already plays a frequent first-contact role in participants' health journeys and in participants' creation of their own information ecosystems. Furthermore, human accompaniment remained critical and desirable during and after the abortion.

Conclusions:
Medication abortion experiences in Canada are shaped by structural racial inequities as much as by emotional and informational needs. These findings point to a clear gap: existing digital and clinical resources are not meeting the cultural and emotional needs of racialized abortion seekers. Hybrid support models (pairing accessible AI-driven information with empathetic human accompaniment) offer a promising path forward and will directly inform the Canadian adaptation of Aya Contigo.

P 61

Perceptions, barriers, and practices related to abortion among indigenous women in Choco, La Guajira, and Nariño, Colombia

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Background:
This study investigated perceptions, practices, and barriers related to abortion access among indigenous women across three Colombian departments. Although abortion was decriminalized up to 24 weeks in Colombia through Constitutional Ruling, indigenous women in Chocó, La Guajira, and Nariño continue to face implementation gaps in abortion access shaped by geographic isolation, structural racism, and tensions between individual reproductive autonomy and collective cosmovisions that frame fertility as central to cultural survival.

Methods:
A qualitative methodology was employed using inductive analysis of participants' lived experiences to explore cultural perceptions of abortion, identify barriers and facilitators within the health system, and examine the effects of limited legal awareness on access to voluntary pregnancy interruption services. Data collection combined documentary review, participant observation, and semi-structured interviews across twelve municipalities. A total of 47 interviews were conducted: 35 with indigenous women aged 18 or older, and 14 with key actors from the health, justice, and protection sectors.

Results:
Three interconnected barrier clusters were identified. Sociocultural barriers were most pervasive: abortion is widely treated as a taboo associated with spiritual imbalance and threats to cultural survival, reinforced by the interaction between Catholic influence and indigenous cosmovisions. Fear of community sanction led many women to seek abortion clandestinely through medicinal plants or travel outside their territories without medical accompaniment, substantially increasing health risks. Institutional barriers included geographic inaccessibility, language barriers, absence of culturally sensitive care, and confidentiality concerns. A third cluster centered on widespread unawareness of C-055, with greater knowledge reported only among some community leaders.

Conclusion:
These findings reveal that legal progress remains largely unrealized at the territorial level. Achieving equity requires culturally adapted communication strategies co-developed with communities, intercultural dialogue honoring both individual autonomy and collective governance, training of health personnel in differential ethnic approaches, and strengthened articulation between the national health system and indigenous health structures.

P 62

Towards safer AI in sexual and reproductive health: a governance framework for purpose-built chatbots

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Background:
Commercial AI tools have become a common entry point for health information, including SRH-related queries. More than 5% of all ChatGPT messages globally are estimated to relate to healthcare, amounting to billions of health-related interactions each week. Despite their growing use, these systems present limitations in accuracy, consistency, and safeguards. This creates an urgent opportunity to develop purpose-built alternatives that provide accurate, evidence-based, and stigma-free SRH information. [OUR ORGANISATION] has developed two hybrid AI chatbots combining dynamic AI-generated responses with predefined conversation flows, enabling personalized interactions while maintaining greater control over sensitive topics and clear pathways to human support.

Objectives:
This presentation introduces an AI governance framework for purpose-built SRH chatbots, demonstrating how governance and system design choices enable safer, rights-based delivery of SRH information through hybrid AI architectures.
Methods: The framework was developed alongside the implementation of two hybrid AI chatbots using large language models (LLMs), curated knowledge sources, system prompts, guardrails, and human oversight mechanisms. An external summary was also created to support transparency with partners and users.

Results:
The framework defines governance foundations, roles, risk management processes, and technical controls across the AI lifecycle. Key domains include data privacy, reliability, bias, inclusivity, transparency, and human-centred care. The hybrid architecture enables safer information delivery through curated knowledge bases, constrained scope, structured conversation flows, and defined escalation pathways to human support. The framework explicitly acknowledges trade-offs, including reduced breadth of knowledge and dependence on continuous knowledge governance.

Conclusions:
Purpose-built AI systems offer an alternative to general-purpose commercial AI by enabling greater accuracy and pro-choice framing of information. Realizing these benefits requires robust governance. This work demonstrates that responsible AI in SRH depends not only on technological capability, but on the safeguards, oversight, and values that shape its use.

P 63

LARC and sterilization in the United States after the 2022 Dobbs Supreme Court Decision: A Comparison of Three States with Different Abortion Policies

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Background:
The June 2022 *Dobbs* decision of the Supreme Court of the United States (SCOTUS) reversed the federal protection to abortion leaving it to individual states to govern access to abortion care, resulting in a wide range of restrictions in states across the US (13 totally ban abortion; 7 ban it at or before 18 weeks gestation).

Objective:
To examine factors influencing initiating long-acting reversible contraception (LARC) and sterilization among Black (B), Latiné (L), and White (W) females in states with varying policies after the 2022 *Dobbs* decision. We compare experiences in three states with abortion restrictions based on gestational limits: supportive/24 weeks (New York; NY), restrictive/12 weeks (North Carolina; NC), and near-ban/6 weeks (South Carolina; SC).

Methods:
We conducted in-depth interviews (N=30) with people aged 25-45 who initiated LARC or sterilization on or after 1/1/22, residing in NY, NC, or SC, exploring state abortion policy and other factors influencing their LARC or sterilization contraceptive decisions, and reproductive health policy recommendations. Interviews were recorded and transcribed, analysis utilized grounded theory methodology through iterative coding, team discussions, analytic memos to identify themes.

Results:
The sample was diverse with regard to state (NY=12, NC=11, SC=7), race/ethnicity (B=15, L=6, W=9), SES (working/lower-middle class=13, upper-middle class=16), and method (LARC=18, sterilization=12). Main reasons associated with choosing LARC or sterilization were Dobbs-related (restricted abortion care; need for highly effective contraception; fear of subsequent policies limiting contraceptive access). Interviewees' opinions about Dobbs reflected great worry that rights were taken away resulting in feeling unsafe and concern for maternal health outcomes and "ripple effects" (e.g., future loss of contraception), expressed more among people who were Latiné, from SC, and/or lower-middle class.

Conclusions:
That protecting bodily autonomy was the strongest recommendation expressed in the sample, suggests an advocacy path forward in states with varying abortion policies.

P 64

Bodies beyond borders: queering the global struggle for SRHR

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Background:
The universal framework of Sexual and Reproductive Health and Rights (SRHR) historically relies on binary and heteronormative structures that marginalize diverse identities. Lesbians, Gays, Bisexual, Trans, Intersex, and Queer (LGBTIQ) communities encounter severe systemic obstacles, including biomedical violence, legal erasure, and administrative barriers across global landscapes.

Objectives:
This institutional exclusion actively pathologizes non-normative bodies and forces vulnerable populations to navigate severe state abandonment. This study aims to explore how LGBTIQ activists navigate, resist, and reimagine reproductive rights within fractured regional landscapes. It seeks to propose a conceptual "queering" of the SRHR framework, shifting the primary focus away from strictly biological reproduction toward bodily autonomy, pleasure, and diversity. Additionally, the research challenges global institutions and health researchers to confront their ongoing complicity in colonial hierarchies.

Methods:
The study utilizes a qualitative research design centered on lived testimonies from queer and trans grassroots activists. Data collection involved semi-structured interviews and participatory dialogues focused on the intersections of identity, systemic power, and institutional exclusion. The study setting spans three Latin American nations: Venezuela, Guatemala, and Argentina. Verbatim activist statements were translated and qualitatively analyzed to evaluate institutional rejections and map community-led resistance models.

Results:
The findings demonstrate that conventional health frameworks systematically produce invisibility, resulting in administrative violence, service denials, and hostile clinical encounters that trigger widespread healthcare avoidance. In response to structural state abandonment, marginalized communities actively construct creative "Architectures of Freedom". These manifest as informal networks of trust, word-of-mouth healthcare recommendations, chosen families, and alternative care infrastructures grounded in collective solidarity.

Conclusion:
The study concludes that community-led care models serve as a radical blueprint for systemic transformation rather than mere temporary substitutes for failed state responsibility. Traditional SRHR frameworks cannot achieve true universality unless they dismantle cis-heteronormative, colonial biases and integrate diversity as a core strength.

P 65

Activity data on abortion in general practice (ADAPT) In Ireland: initiating a sustainable, standardised database for EMA provision in Irish primary care.

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Background:
Ireland's abortion care model involves General Practitioners (GPs) delivering early medical abortion (EMA) within a funded standardised three-visit care protocol. Statutory reporting on Irish abortion provision limits itself to counts of terminations satisfying statutory requirements but wholly inadequate as standardised, longitudinal efficacy, safety and quality data. In response, the authors initiated a university-GP practitioner partnership Activity Data on Abortion in General Practice (ADAPT) project.

Objective:
This paper outlines the development and methodology of ADAPT. It reports on key findings from year one. It highlights the need for sustainable, standardised, longitudinal monitoring of primary care abortion provision integrated into health-system data infrastructure and sets out future research agenda for the project.

Methods:
ADAPT is a partnership of the GP-led Southern Task-force on Abortion and Reproductive Topics (START) and Trinity College Dublin. The tool collects 49 prospective, anonymous patient and provider measures digitally through a secure Microsoft Forms platform hosted by Trinity College Dublin. Data will be downloaded to REDCap on SharePoint for retention. Routine quality checks are conducted for completeness and plausibility. Patient agreement is integrated on practice patient EMA consent forms. Research Ethics Committee (REC) approval is provided by Trinity College Dublin.

Results:
Between August 2025 and June 2026, 124 of 420 EMA contracted GPs signed consent and data-sharing agreements with the project and submitted 1160 returns. Headline results report 95.7% of EMA's completed were successful and required no additional treatment, 1.7% of EMA's failed and 2.6% required additional treatment. 8.5% of patients were referred to secondary care from first GP visit.

Conclusions:
Integration of ADAPT into existing health system data infrastructure would ensure scalability and security to a standard of most healthcare settings where EMA is provided. Multiple work-packages can be developed from this infrastructure employing mixed methodologies for focused analysis of key future service and policy concerns.

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General practitioners' perspectives on structural barriers to early medical abortion in Ireland

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Background:
Ireland's Health (Regulation of Termination of Pregnancy) Act 2018 legalised abortion for the first time, structuring early medical abortion (EMA) provision primarily through general practice. Despite this transformation, evidence indicates inequitable access, with structurally marginalised populations disproportionately unable to access timely care.

Objectives: Objectives are: (1) explore the practical, emotional, and organisational demands GPs encounter in providing EMA; (2) examine GPs' perceptions of barriers to EMA access; (3) understand how GPs interpret their professional role and responsibility; and (4) identify the organisational, infrastructural, and policy supports GPs view as necessary for equitable EMA care.

Methods:
A qualitative study using semi-structured focus groups with GPs currently providing EMA in the Republic of Ireland will be employed. Purposive sampling via the DeepEnd and START networks will recruit GPs delivering EMA in areas of social and economic deprivation. Three to four online focus groups of six to eight participants are planned, transcribed verbatim and analyzed using inductively coded thematic analysis.

Results:
This study is in the design phase; empirical results are not yet available. Anticipated findings, grounded in the literature and the inverse care law framework, include concentration of providing practices in affluent, urban settings; cumulative structural barriers for patients in Direct Provision, Traveler communities, and rural poverty; inadequacy of current legislative provisions; and insufficient integration of interpretation, psychosocial, and outreach services.

Conclusions:
Persistent access inequity in post-legalization Ireland reflects structural features of health system design rather than legal insufficiency alone. Administrative reforms recommended in the 2023 independent expert review are necessary but insufficient unless the distributional logic of the opt-in model and broader inverse care dynamics are addressed. Findings will contribute to the evidence base for structural reform of EMA provision in Ireland, with implications for comparable jurisdictions navigating the gap between legalization and equitable access.

P 67

A dual opportunity for women's health: aligning family planning and anemia strategies

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Background:
Progress on reducing anemia among women has stalled globally, with iron deficiency affecting nearly a billion women worldwide. Poor nutrition is the most cited cause, but heavy menstrual bleeding (HMB), estimated to affect ~ 500 million women globally, is often overlooked. Evidence linking hormonal contraceptive use and improved anemia status remains unintegrated into anemia control strategies.

Objectives:
This review aimed to synthesize evidence on the relationship between HMB, hormonal contraception, and anemia; examine HMB prevalence across low- and middle-income countries (LMICs); and develop recommendations for incorporating this evidence into anemia control.

Methods:
We reviewed three literature categories published 2011–2026: multi-country HMB prevalence studies; DHS analyses and reviews on contraceptive method and anemia; and national anemia strategy documents from two LMIC settings, India and the African Union region. Search terms included heavy menstrual bleeding prevalence, DHS, iron deficiency anemia, contraceptives, and anemia control strategies. Findings are presented narratively.

Results:
HMB prevalence is higher than previously reported, ranging 17–65%, and is high even in high-income settings: a Netherlands survey of 42,000 women found 53.7% prevalence, while a six-country Africa–South Asia study found 46% on average, from 38% in Uganda to 77% in Nepal. DHS analyses across 46 countries showed contraceptive users had significantly lower odds of anemia than non-users (OR 0.52, 95% CI 0.37–0.73), strongest for injectables and implants. National and regional anemia control strategies remain supply-focused, not addressing menstrual blood loss as a cause, nor is detection of HMB included in public health programs.

Conclusions:
HMB and anemia carry substantial physical, mental, social and economic costs for women. Hormonal contraceptives offer an opportunity to address unintended pregnancy and anemia together, yet no programme integrates these issues. High-burden countries should generate evidence on integrated programmes, and revise anemia strategies to incorporate menstrual health alongside supply-side approaches.

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Creative labor imagining alternative reproductive futures: socially engaged art, reproductive citizenship and abortion utopias

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Background:
Abortion utopias can be more easily imagined through socially engaged art (SEA) practice, than it might through more traditional qualitative methods of research. SEA, where artists facilitate group, community and interpersonal exchange, often addresses social concerns indirectly but effectively.

Methods:
SEA, and creative arts-based research methods, have been embraced by scholars across anthropology, sociology, law and public health, because creative methods can enrich how we understand our social and material worlds, by bringing new insights.

Results:
Researchers found that these methods meant engaging people on feelings and experiences of their abortions or providing abortions became much more open
SEA methods are often used to increase awareness on an issue through engagement and dialogical practice. It generates new ways of knowing through instantaneous, collaborative, materialized and embodied inquiry. This article considers the reproductive and creative labor processes of the SEA within a setting where abortion has been recently liberalized. This paper will sketch out reproductive and creative labor concepts, giving examples of the intersections of Irish abortion activism, creative and artistic interventions that render reproductive and activist labor visible. This paper will be relevant to abortion and reproductive justice movements across the globe, as methods tested in Bangkok and Kenya will be discussed.

Conclusion:
It demonstrates how to utilize cross disciplinary research with mixed cohorts of abortion, art and repro health advocates, and researchers. It also presents the Abortion Utopias Toolkit and its findings to enable other organizations and researchers to use in their settings.

Legal Aspects

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US-state abortion laws post-*Dobbs*: how do they stack up against national-level laws in 199 countries?

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Background:
In June 2022, the US Supreme Court overturned the right to abortion at the federal level. It's crucial to periodically examine how US states have responded.

Objectives:
Since 1998, national abortion laws have been ordered into intuitive, mutually exclusive categories of increasing legal grounds. This universally applicable categorization starts with no legal ground ("outright prohibition") and successively adds grounds until the most liberal category ("no restriction as to reason"). US states, 17 of which substantively changed their abortion laws post-*Dobbs*, have not yet been placed on this continuum to show, at-a-glance, where they stand compared with the world's national-level laws.

Method:
We distribute all US states and DC (and women of reproductive age) into cumulative categories. Although all each legal ground has its own gestational limit (often indirectly through omission), this descriptive analysis quantifies such limits for on-request abortions only.

Results:
Thirteen states moved backward from Category 6 (on-request); five landed in Category 2 (save pregnant person's life) and eight in Category 3 (save life and protect physical health). *Dobbs* has resulted in several ignominious firsts: Many states' laws insist that medical emergencies *cannot* involve mental health (13), or threats of self-harm, including clinical diagnosis of suicidal ideation (14). Four states that allow on-request abortions reduced their gestational limit to halfway through the first trimester. Of these, 3 are the first jurisdictions worldwide to jettison the universal standard of weeks of gestation and instead use the highly variable detection of a fetal "heartbeat."

Conclusions:
The United States is the first country to move from a national right to abortion to states being able to severely limit legal grounds. This means 70 million women have to travel out-of-state for self-determined abortions or use medication abortion via telemedicine, options often unavailable to those with the fewest resources and greatest needs.

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Expanding safe abortion access in Nepal's most underserved province: Barriers to service site accreditation

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Background:
Although Nepal legalized abortion in 2002 and expanded access through the Right to Safe Motherhood and Reproductive Health Act 2018, equitable access to safe abortion services (SAS) remains limited in marginalized regions. Madhesh Province, one of Nepal's most underserved provinces with poor health and socio-economic indicators, continues to face significant reproductive health inequities. Since 2015, accreditation authority for SAS has been decentralized to provincial and local governments to strengthen local ownership and expand access. However, evidence on how decentralization has affected abortion service availability remains limited.

Objectives:
To assess the status of SAS accreditation in Madhesh Province and identify barriers affecting accreditation of public health facilities.

Method:
A cross-sectional mixed-methods study was conducted across 24 municipalities in all eight districts of Madhesh Province using systematic sampling. Public health facilities were mapped, and key informant interviews were conducted with health facility in-charges. Ethical approval was obtained from the Nepal Health Research Council.

Results:
Among 277 public health facilities assessed, only 39 were accredited as SAS sites and only 24 were functional. Accreditation was concentrated in higher-level facilities, while no basic health service centers were accredited. Among non-accredited facilities, 91% identified lack of trained providers as the primary barrier. Additionally, 32% incorrectly believed that non-birthing centers were ineligible for accreditation, reflecting gaps in understanding of accreditation criteria. Other barriers included inadequate infrastructure and equipment, lack of institutional initiation, and proximity to another accredited site.

Conclusions:
Despite more than two decades since legalization, only 8.7% of assessed public facilities were accredited and functional. The findings highlight persistent health system barriers that disproportionately affect underserved communities and underscore the need for strengthened provider training, clearer accreditation mechanisms, and equitable expansion of abortion services.

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The influence of national policies and regulations on the access to abortion care: a comparative study between Belgium, Estonia and the WHO guidelines according to the latest evidence on safe abortion care.

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Background:
Access to safe abortion care across EU member states is shaped by various factors that act as barriers or facilitators. Despite evidence-based WHO guidelines, national abortion regulations differ regarding gestational age limits, waiting periods, counselling requirements, third party consent, financial coverage, abortion methods, criminal sanctions, abortion providers and conscientious objection.

Objectives:
This literature review compares abortion care frameworks in Belgium and Estonia using the 2022 WHO Abortion Care Guideline as a reference and examines how national policies influence access to safe abortion services.

Methods:
A scoping literature review was guided by the Population/Concept/Context framework. Qualitative, quantitative, mixed-methods, and grey literature published between 2010 and 2025 in English, French, Dutch, or Estonian were included. Data were collected from PubMed, ScienceDirect, WHO publications, government documents, and other credible grey literature sources. Relevant legislation, policies, guidelines, and legal documents were analyzed and complemented by sources from informal expert consultations.

Results:
Sixty-seven sources were included. In Belgium, abortions are predominantly surgical and provided by physicians in licensed centers or hospitals. Access is limited to 14 weeks from last menstrual period and requires counselling and a six-day waiting period. In Estonia, abortions are primarily medical, provided by gynecologists, and available up to 12 weeks from last menstrual period without further mandatory conditions. In both countries, socio-economic barriers may limit access for uninsured individuals, while the impact of conscientious objection remains insufficiently monitored. Restricted accessibility may contribute to delayed care, increased health risks, and cross-border travel for abortion services.

Conclusion:
Although both countries broadly align with 2022 WHO Abortion Care Guideline recommendations on safe abortion provision, differences in gestational age limits, mandatory requirements, service delivery models, and socio-economic barriers continue to affect equitable access. Impaired access can increase health risks, reinforce social inequities, and lead to cross-border travel or unsafe alternatives.

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Regulatory policy changes and Mifepristone access through pharmacies in Australia

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Background:
Prior to 2023, Australia imposed dispensing restrictions on mifepristone similar to the U.S. Food and Drug Administration's (FDA) Risk Evaluation and Mitigation Strategy (REMS) for mifepristone. This included requirements for physicians and pharmacists to complete training and register as prescribers and dispensers. These restrictions were removed in August 2023, allowing for mifepristone to be prescribed and dispensed like other medications.

Objectives:
We assessed whether the number and geographic distribution of pharmacies ordering mifepristone increased after the 2023 regulatory changes.

Methods:
We analyzed sales data for mifepristone (marketed for early medication abortion in a combi pack, MS-2 Step®, with misoprostol) from the sole Australian distributor to community and hospital outpatient pharmacies for two years before (August 2021-July 2023) and after (August 2023-July 2025) the regulatory changes. We conducted an interrupted time-series (ITS) analysis to investigate associations between the 2023 regulatory change, and changes in the number of unique pharmacies ordering mifepristone each month and the number of postcodes with at least one ordering pharmacy each month.

Results:
We found that that this regulatory change resulted in a significant immediate increase in the number of pharmacies ordering mifepristone (86 additional ordering pharmacies than expected (95% CI, 16-157)) and a significant acceleration of the increasing trend by 15 (95% CI, 10-20) additional pharmacies per month. By July 2025, an additional 4.4% (95% CI, 2.4%-6.4%) of postcodes had at least one ordering pharmacy than expected, amounting to a 20% (95% CI 10%-31%) increase nationally.
Conclusions
The findings confirm that removing mifepristone prescribing and dispensing restrictions results in immediate and sustained expansion of mifepristone access for medication abortion.

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Healthcare professionals' experiences of caring for women applying for abortion after 18 weeks of gestation

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Background:
In Sweden, abortion is permitted up to 21 weeks and 6 days of gestation, but beyond 18 weeks requires authorization from the National Board of Health and Welfare's legal council. Decisions are based on medical and psychosocial assessments at the abortion clinics and cannot be appealed. Denied applications are not accompanied by any explanations, and decision-making procedures lack transparency. Healthcare professionals must navigate stigma, legal restrictions, and ethical dilemmas while supporting women in vulnerable situations. Their experiences of this process remain underexplored.

Objectives:
To describe healthcare professionals' experiences of caring for and supporting women applying for abortion authorization after 18 weeks of gestation.

Methods:
A qualitative descriptive study was conducted using semi-structured interviews with 15 healthcare professionals (midwives, obstetricians, gynecologists, resident doctors, and social workers) at Sahlgrenska University Hospital/Östra Hospital, Gothenburg, Sweden. Data were analyzed using Malterud's Systematic Text Condensation. Ethical approval was obtained.

Results: Four themes with subthemes emerged:
The approval process increases patient vulnerability and psychological burden: loss of autonomy and control; intrusive and self-exposing processes; reinforcement of pre-existing vulnerability.
Healthcare professionals' role between support and gatekeeping: supporting patients during uncertainty; responsibility for assessment and documentation; representing a system beyond one's control.
Organizational barriers to effective and high-quality abortion care: administratively induced waiting and delayed care; time pressure and complex case management; outdated administrative systems.
Ethical and legal dilemmas in the approval process: lack of transparency and uncertainty in decision-making; concerns about legal security and equitable care; reflections on the legitimacy of the process.

Conclusion:
The authorization process contributes to patient vulnerability and constrains healthcare professionals' ability to provide timely, equitable care. Administratively induced barriers and lack of transparency of the decision-making process create distress among professionals.

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Witnessing the problem of discontinuous early abortion care in cases of failed EMA up against a legal time-limit

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Background:
One of the unanticipated consequences of Ireland's new system of time-limited abortion care is a policy that denies an ordinary follow-up abortion when pregnancy is ongoing beyond 12 weeks in those rare cases (1-2%) where a lawful early medical abortion has failed. This is a policy which is having harmful effects and leading to suboptimal abortion care in ways that exacerbate difficulties for underserved populations.

Objectives:
The paper sets out to identify how current EMA guidance in Ireland understands the problem of discontinuous abortion care in cases of failed EMA up against the time limit, as part of the case for developing and advocating less harmful policy responses that are legally permissible.

Methods:
This paper draws on Bacchi's 'What's the Problem Represented to Be' (WPR) approach to take a deeper look at the legal problem to which Irish EMA guidance responds and uses 'open legal witnessing' to ask if doctrinal legal method can generate alternative less harmful solutions.

Conclusion:
The guidance represents the problem of discontinuous early medical abortion as having a legal cause, drawing on the Chief Medical Officer's 2018 opinion. Following Bacchi, it is possible to understand the problem differently, and even to solve it through a better, more just application of legal rules to the factual problem of failed EMA. The current representation of the problem relies on a misunderstanding of law as inevitably fact-neutral, single-sourced and inflexible. Rather basic doctrinal legal method understands law as a process that necessarily works with facts, has multiple sources, and requires some flexibility in fitting abstract rules to concrete factual situations.

Conclusion:
It is possible legally to apply a 12-week time limit so that it accommodates continuing abortion care in cases where EMA has failed up against the time limit.

P 75

Witnessing barriers to abortion care in Ireland: Interrogating an under-developed legal pathway to care

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Background:
Access to abortion in Ireland is regulated by the health (Termination of Pregnancy) Regulation Act 2018. This sets out pathways to lawful care, including where there is a risk to life or serious risk to the health of the woman (section 9). However, this pathway remains under-developed, with on average 20 women a year obtaining an abortion under section 9 since 2019.

Objectives:
To illustrate the shortcomings in the operation of this pathway using *DE (A Minor)* [2025] IEHC 604 as a case study. Fifteen-year-old DE, who was found to lack capacity to consent to abortion, had threatened to end her own life if she was unable to access care. While DE ultimately obtained an abortion, authorized by the court in her best interests, the judgment exposes how procedures imposed by those charged with supporting DE and inaccurate readings of the legal framework gave rise to barriers to access.

Methods:
This paper draws on critical socio-legal perspectives and Fletcher's methodology of feminist legal witnessing to interrogate the court's treatment of abortion and capacity to consent, and to advance alternative legal approaches to enhance access within the current legal framework

Results:
Failure to provide meaningful clinical guidance on the section 9 pathway, and misunderstandings of the legal framework in relation to abortion and capacity to consent, lead to unnecessary obstacles to care, and/or women not receiving timely care.

Conclusion:
Clearer guidance and a clearer understanding of the legal position is required to enhance access to lawful abortion care under section 9. Young people seeking care face additional barriers, which are exacerbated by the lack of legal clarity around capacity and consent to reproductive healthcare for young people in Ireland.

P 76

Qualitative impact of abortion bans on health equity in the United States: findings from a National Study

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Background:
Since 2022, over 20 US states have had active total abortion bans or severe restrictions. These restrictions may worsen health inequities by differentially impacting populations based on societal dynamics of power and oppression marked by sociodemographic characteristics.

Objectives: To understand the financial and psychosocial burdens of traveling for abortion care in the contemporary US.

Methods:
We conducted interviews with clinicians, care navigators, advocates, and other professionals and volunteers involved in supporting US abortion travelers. Semi-structured interviews explored the barriers participants observed, queried their ideas for interventions to ameliorate them, and highlighted which populations are most impacted. Participants were sampled for diversity on geographic location (ban vs. abortion permissive state, Census region) and role in abortion care navigation. We coded manuscripts using a combination of deductive and inductive codes and a multi-coder consensus method, and identified emergent themes related to health equity.

Results:
We completed 36 interviews with individuals in 15 states and Washington DC, and two national organizations, before reaching thematic saturation. Participants included clinicians and clinical staff (n=19) and workers and volunteers at charitable funds that support travelers (n=17). Participants observed the greatest barriers related to income, structural barriers due to racism, and being geographically far from a legal abortion provider. Participants observed that individuals who were immigrants, non-English speakers, or feared abuse or deportation by US Immigration and Customs Enforcement due to their perceived race or nationality, faced unique and escalating barriers to care. Participants suggested repealing abortion restrictions and increasing charitable funding and outreach to individuals seeking abortion who may not be aware of fund support.

Conclusions:
State-level abortion bans worsen health inequities through unique impacts on individuals affected by racialized xenophobia. Quantitative studies may fail to detect this phenomenon due to small sample sizes of affected individuals or missing variables on immigration status.

Medical Abortion

P 77

Strengthening access to safe self-managed abortion through friendly pharmacies in conflict-affected Cameroon: evidence from a four-year initiative

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Background:

Access to safe self-managed abortion (SMA) remains constrained in conflict-affected regions, where weakened health systems, limited mobility, and persistent stigma hinder access to reproductive health services. In Cameroon, a four-year initiative was implemented to expand access to accurate SMA information and quality medical abortion (MA) through a network of "friendly pharmacies"—drugstores, midwives, community clinics, and other trusted frontline providers. The program currently collaborates with 71 providers across affected communities.

Methods:
Drawing on findings from 12 abortion seekers, 8 abortion service providers, and a focus group of 8 sex workers, the intervention combines provider mapping, comprehensive training, and continuous supportive supervision. These components aim to improve provider readiness, strengthen referral pathways, ensure clinical accuracy, and sustain quality counseling.

Results:
Results indicate significant improvements in SMA experiences. Most abortion seekers—primarily women aged 21–32, 10 of whom relied on medication abortion—reported high levels of fear, confusion, and isolation before receiving support. Accompaniment markedly reduced psychological distress, with providers observing that clients typically regained calm and confidence after counseling. Physical complications such as severe cramping, heavy bleeding, and prolonged recovery were common, yet accompaniment facilitated safer outcomes through timely symptom monitoring, medication reminders, and referrals. Social stigma remained pervasive, with many participants reporting secrecy even from partners; however, accompaniment fostered trust, confidentiality, and better decision-making, contributing to greater community confidence in friendly pharmacies.

Conclusion:
Overall, the model demonstrates that equipping pharmacy-based providers with accurate knowledge, supportive supervision, and non-judgmental counseling can expand safe SMA access in fragile settings. Its integrated, community-driven design offers a scalable approach to strengthening reproductive health resilience amid conflict and restrictive legal environments.

P 78

Introducing the app „Alli“: support for medical terminations of pregnancy (abortions and “missed abortions”)

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Background:
In 2025 the app “Alli” was launched in Germany. It was developed to provide support for the medical termination of an unwanted pregnancy or a „missed abortion“. Initially, the app was available only in German; since early 2026, it has also been available in English and the download is possible in all countries. The app is free of charge and data-secure.
„Alli“ offers both a personalized section with a calendar feature to help with taking mifepristone, misoprostol, and accompanying medication, as well as a detailed FAQ list. The app allows the user to specify whether it is an abortion or a miscarriage.

Methods:
We suspect that using the app can provide emotional support, both for users seeking abortions and for those with a miscarriage.

Results:
To confirm this, a prospective, multicenter, randomized, open-label-controlled trial (Eva-SAB) is planned. In this study, the intervention group receives information about the app in addition to routine medical counseling, while the control group receives only routine counseling. The primary endpoint is the change in mental distress, measured using various questionnaires on mental distress, life satisfaction, self-esteem, and self-efficacy.

Conclusion:
The study is scheduled to begin in the summer of 2026.
All information about the app can be found on www.alli-app.com.

P 79

Patient experiences with abortion care: a mixed-methods study highlighting ultrasound autonomy, quality of care, and pain management

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Background:
While Dutch abortion care is generally highly rated, clinical protocols often mandate routine pre-abortion ultrasounds, contrasting with 2022 World Health Organization guidelines. Evidence regarding patient experiences with these ultrasound protocols, interpersonal care, and aftercare remains sparse.

Objectives:
This study investigated patient experiences in Dutch abortion care, focusing on patient autonomy, preferences, and the impact of pre-abortion echoscopy, alongside general care delivery and aftercare.

Methods:
A mixed-methods study combined a quantitative online survey (n=128) of individuals who had an abortion within the past five years, with two focus groups (n=10). Questionnaires evaluated interpersonal care, pain management, and ultrasound protocols, while focus groups provided deep qualitative insights into the clinical journey.

Results:
Overall care was highly rated; 90% felt respected and 88% experienced no judgment. However, profound autonomy deficiencies emerged regarding routine ultrasounds. Quantitatively, 71% felt they could not opt out, though 38% explicitly preferred to. Furthermore, 23% reported explicit consent was not requested, and 18% were denied the choice to view the ultrasound screen. Qualitatively, participants described the ultrasound as a rigid requirement rather than an autonomous choice. It was frequently emotionally confronting due to societal associations with wanted pregnancies, exacerbated by insufficient explanation. Concurrently, 41% of medical abortion patients reported insufficient pain management, and 49% received no aftercare.

Conclusions:
Although Dutch abortion care is structurally respectful, patient-centeredness can be enhanced by re-evaluating mandatory ultrasound protocols. Incorporating explicit informed consent, offering a genuine choice to opt out of echoscopy per international guidelines, and mitigating emotional impact through better communication are critical for fostering reproductive autonomy.

P 80

30 mg compared with 60 mg of Ulipristal Acetate prior to Misoprostol for early medication abortion: a double-blind, placebo-controlled randomized trial

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Background:
Medication abortion using mifepristone and misoprostol is safe and effective. Yet, multiple factors limit access to mifepristone. Identifying effective alternatives to mifepristone is essential for expanding access to safe medication abortion. Ulipristal acetate, with a similar chemical profile, presents a promising alternative.

Objectives:
To evaluate whether a single 30mg dose of ulipristal acetate maintains comparable efficacy, safety, and acceptability to a single 60mg dose when used in combination with misoprostol for medication abortion through 63 days of gestation.

Method:
Gynuity Health Projects is conducting a clinical trial to compare 30mg vs 60mg ulipristal acetate taken orally in-clinic, followed by misoprostol 800mcg taken buccally 24 hours later at home. The study is enrolling participants (n=426) at two public hospitals in Mexico City and determining gestational age and abortion status with ultrasound. For participants who do not attend a follow-up visit, self-reported outcomes are used to assess abortion resolution. Primary outcome is complete abortion without need for additional intervention. Secondary outcomes include incidence of side-effects and complications, and acceptability of the two regimens.

Results:
In a previous proof-of-concept study, a regimen of 60mg ulipristal acetate plus 800mcg misoprostol resulted in complete abortion in 129/133 participants (97%), with no serious adverse events and high satisfaction and acceptability. These findings supported further investigation to evaluate dose optimization in a randomized setting. Enrollment in the current trial is ongoing and expected to be completed in advance of the conference; results will be available at the time of presentation.

Conclusions:
The study addresses a critical evidence gap regarding optimal dosing of ulipristal acetate for medication abortion while strengthening evidence on the efficacy of the 60mg dose in a larger, controlled population. Demonstrating comparable efficacy at a lower dose could reduce cost, expand availability, and support broader implementation of medication abortion regimens involving ulipristal acetate.

P 81

Partners' perspectives on abortion care

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Background:
Abortion care in Sweden ensures access to safe, publicly funded services and emphasizes women's autonomy. In Sweden, abortion is available on request up to 18+0 weeks of gestation. While research has primarily focused on women's experiences, partners' perspectives remain underexplored despite evidence suggesting that their experiences involve psychological, social, and relational dimensions. Some studies indicate risks such as psychological distress and social challenges among partners, while others highlight broader patterns in which decision-making is shaped by relational dynamics, financial considerations, and perceived readiness for parenthood. Together, these findings underscore the need for a more nuanced understanding of partners' experiences.

Objectives:
To explore partners' experiences of abortion and identify their informational and supportive needs during the care process.

Methods:
A qualitative study using semi-structured interviews with 16 partners of women undergoing inpatient abortion (≤18+0 weeks) at a Swedish university hospital. Participants were recruited purposively. Interviews were conducted on the day of the abortion, audio-recorded, transcribed verbatim, and analyzed using thematic analysis (Braun & Clarke, 2022).

Results:
Three main themes were identified: (1) *Decision-making in context*, where partners balanced support with respect for women's autonomy and assumed responsibility once pregnancy became real; (2) *Patterns and pathways of information-seeking and support needs*, highlighting diverse, situational needs and multiple sources, including healthcare professionals, digital platforms, and informal networks; and (3) *Navigating emotional challenges*, where guilt, ambivalence, and concern coexisted with a strong focus on prioritising the woman's well-being. Many partners suppressed their own emotions to avoid influencing the decision.

Conclusions:
Partners are active participants in abortion care, navigating a complex role shaped by responsibility and restraint. Recognizing their informational needs, strengthening knowledge of family planning, and supporting partner involvement in contraceptive counselling may improve care. More inclusive, person-centred approaches could enhance both relational outcomes and overall quality of abortion care.

P 82

Abortion in Burgos (Spain) - descriptive observational study: user profile, procedure, pain, outcomes and contraception

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Background:
Medical abortion began in Burgos in January 2022. It is necessary to understand the user profile, the procedure, and the results in order to improve care.

Objectives:
Establish the profile, tolerance and complications.
Assess pain and analgesia.
Assess contraception before and after abortion

Methods:
Descriptive observational study
Inclusion: Women who underwent medical abortion (Burgos 2022-2025)
Exclusion: Surgical abortion. >12 weeks of gestation. Contraindication

Results:
962 women included.
Age: 20-29: 48.65%.
Parity: No 62.16%.
Previous abortion: 77.55% No.
Nationality: 65.90% Spanish.
Gestational age: 93.55% ≤8 weeks.
Prior contraception: No use 47.5%, Barrier 34.4%, COCs 12.3%.
Not follow up: 7.48%
Time of onset of bleeding: 2 hours (24.24%). 1.18% >8 hours.
Doses in pregnancies ≥9 weeks: 2 (35%). 4-5: only 15%.
Failure Procedure: 0.73%. Second dose 1.77%.
Pain (VAS score): ≤7 61.54%.
Analgesic doses: Dexketoprofen: 1 (30.77%) and 3 (49.23%). Paracetamol: 0 (20.22%) and 3 (48.76%). Tramadol: 0 (64.62%).
Subsequent contraception: COCs (21.3%), Implants (18.4%), Barrier (16.6%), Copper IUDs (14.4%).
Complications: 0.83% hospitalization. Anemia-causing metrorrhagia (53.33%) and pain (40%).

Conclusions:
The study allows us to gain a very precise understanding of the women who undergo abortions
The typical user is a 20-24 years old woman. Number of children: 0. Previous abortion: 0. Nationality: Spanish. Gestational age: ≤6 weeks 61.85%. Bleeding within 2-3 hours. Only 1.18% ≥8 hours. 1.77% second dose. Success rate 99.27%, follow-up 92.52% and complications 0.83%, confirming the safety. 61.54% VAS score of ≤7, treated with 3 dexketoprofen, 3 paracetamol, and no tramadol.

Comparing contraception before and after abortion, decrease Barrier (34.4%-16.6%), decrease No use (47.5%-3.0%), and increase Hormonal and Mechanical methods.
This is a very promising approach, although further analysis will be necessary to confirm its statistical significance, gain a better understanding of our population, and improve pain management and contraceptive counseling.

P 83

Mystery caller study of medication abortion access in Maritime provinces in Canada

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Background:
The implementation and deregulation of mifepristone for medication abortion (MA) in 2017 across Canada may have improved access barriers in the Maritime provinces (New Brunswick, Nova Scotia, and Prince Edward Island). The role of pharmacies in abortion access in the Maritimes has yet to be studied. Whether the implementation of MA has improved access remains unknown.

Objectives:
To assess the availability of mifepristone in pharmacies across the Maritimes.
Method: We conducted a mystery caller study among all pharmacies in the Maritime provinces. We made calls in English or French during winter 2026, entering data simultaneously. We used descriptive statistics to analyze availability by rurality, store category (chain, franchise, banner/independent) and province.

Results:
Among 567 community pharmacies in the Maritimes, we achieved a 100% response rate. Of these, 495 (87%) could fill a mifepristone prescription within three (3) days. Twenty-eight of the 72 pharmacies (39%) that did not dispense mifepristone provided a referral to another pharmacy. Small-medium urban Maritime regions (populations 10,000 - 99,999) had the highest proportion of mifepristone-dispensing pharmacies (202/228, 89%). Compared to franchises, chain pharmacies had the lowest proportion of mifepristone-dispensing pharmacies (164/198, 83%).

Conclusion:
Significant mis- and dis- information about how to access abortion persists in Canada. Our findings provide insight into patient experiences and help abortion-seekers and providers identify where mifepristone can be accessed. Additionally, findings can support navigation tool creation to address information gaps surrounding MA care pathways in Canada.

P 84

Adoption of medication abortion in the Canadian Maritime region: a qualitative study

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Background:
The Canadian Maritime provinces (New Brunswick (NB), Prince Edward Island (PE) and Nova Scotia (NS)) have long experienced unique barriers in access to abortion services. Important policy changes at the national and provincial levels in the past decade created potential for substantial access improvements.

Objectives:
This qualitative interview and focus group study aimed to understand the factors that facilitated or hindered adoption of mifepristone in the Maritimes after its implementation in Canada in 2017.

Methods:
We conducted qualitative interviews and focus groups with abortion care providers in the Maritime provinces to explore changes to practices from 2014-2024 and what factors supported or hindered implementation of mifepristone in abortion services. We conducted thematic analysis and mapped results to Diffusion of Innovation factors.

Results:
We completed 16 interviews and three focus groups, with a total of 38 participants across the three provinces. Thematic analysis identified eight themes: A prescription unlike any other; Improving care; Shifting attitudes; Relationality; Intentional spread; Complementary changes; Hospital resources; and Pharmacists in the circle of care. Themes were mapped on to Diffusion of Innovation factors that supported innovation adoption among users in the region.

Conclusion:
The results of this qualitative study present an optimistic counterpoint to longstanding discourse about abortion access in the Canadian Maritime region, providing evidence of enthusiastic adoption of medication abortion as a strategy to overcome historical challenges to abortion access. Findings are relevant to other regions globally with historic stigma and policy barriers and high proportions of people living rurally.

P 85

Why qualitative research matters: understanding experiences of early medical abortion at home

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Background:
In recent years, telemedicine pathways facilitating early medical abortion (EMA) at home have been introduced in the UK. Quantitative evaluations demonstrate safety, effectiveness and high acceptability, but can overlook nuance in the experiences of those who found the process difficult. As home EMA has now become the primary mode of abortion provision across the UK, understanding these experiences is essential for improving care.

Objectives:
We explored the physical, emotional and social experiences of individuals undergoing EMA at home and identified aspects of the care pathway that could be improved.

Methods:
Seventeen semi-structured telephone interviews were conducted with individuals who had EMA at home during the COVID-19 pandemic. Interviews explored expectations, bodily experiences, emotional responses and sources of support. Data were analysed thematically using a framework approach.

Results:
We identified two interrelated themes. First, many participants described distressing bodily experiences. Pain, vomiting, diarrhoea and heavy bleeding were often reported as more intense and frightening than anticipated. Descriptions of abortion pain as “period-like” were perceived as misleading, contributing to fear and distress. Second, participants described uncertainty about what would happen, how long symptoms would last, and whether their experiences were “normal.” Social isolation often intensified these feelings. Some felt unsupported, while others emphasized the importance of informal support networks, telemedicine helplines and reassurance from healthcare professionals.
Across both themes, participants highlighted both the advantageous and empowering aspects of EMA at home and the moments where clearer information or more proactive support would have reduced anxiety and distress.
Conclusions Although home EMA is safe and effective, qualitative research highlights experiences that are not captured through quantitative measures alone, and which can be conceptually generalisable. Improving anticipatory guidance, communication about the range of possible bodily experiences and access to support could improve experiences of home EMA care.

P 86

[Chatbot A], the pioneering abortion chatbot: advancing self-managed abortion accessibility in the era of AI

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Background:
[Chatbot A], a self-managed abortion (SMA) information chatbot, was developed to meet people in the digital spaces they already occupy, providing private, stigma-free, and evidence-based support. Its global use provides unique insights into how users across different regions engage with an abortion chatbot, and how AI is reshaping these interactions.

Objectives:
This presentation shares key findings from the first large-scale analysis of global engagement with [Chatbot A], complemented by early learnings from the integration of AI within the chatbot. It explores regional variations in abortion information-seeking behaviour and how user interactions have evolved with the introduction of a hybrid model combining structured conversation flows with AI-generated responses.

Methods:
The presentation draws on a study published in Contraception, which analyzed 95,281 anonymized conversations across 172 countries between 2022 and 2024, examining conversation pathways, session duration, and engagement patterns. These findings are complemented by emerging insights from [Chatbot A]'s AI-driven implementation.
Results: The study revealed substantial global demand alongside important regional differences. Users in Latin America and Africa engaged in longer, more diverse conversations, seeking detailed guidance on medical abortion protocols. Users in North America and Asia more commonly sought narrower information on pill access. Early AI implementation data shows shifts toward more open-ended conversations and greater ability to address individual contexts, alongside a greater need to balance conversational flexibility with guided pathways for sensitive interactions.

Conclusions:
[Chatbot A]'s global reach confirms clear demand for abortion chatbot services. Regional variation in use underscores the importance of tailoring digital SRH solutions to diverse user realities. The hybrid AI model demonstrates the potential to deliver more adaptive, personalized support while maintaining the consistency and safeguards required for safe abortion care.

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Psychological outcomes following second-trimester termination of pregnancy: associations with diagnostic and decision-making intervals; a cohort study

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Background:
Prolonged diagnostic and decision-making trajectories after the prenatal diagnosis of fetal anomalies may contribute to adverse psychological outcomes following termination of pregnancy (TOP), owing to the extended uncertainty and stress associated with prenatal diagnostic processes.

Objectives:
To investigate whether the duration of diagnostic and decision-making intervals following prenatal diagnosis of fetal anomalies is associated with psychological outcomes after TOP, and to identify factors associated with prolonged intervals.

Method:
A single-site mixed prospective and retrospective cohort study of parents undergoing TOP for fetal anomalies (n = 778). Timing intervals from initial referral to diagnosis, diagnosis to TOP, and initial referral to TOP were analysed. Self-efficacy was assessed at baseline using the General Self-Efficacy Scale. Psychological outcomes, including prolonged grief disorder and depressive symptoms, were measured at 6 weeks and 4 months using validated questionnaires. Associations were examined using multivariable logistic regression adjusted for psychiatric history, gestational age at termination, and post-TOP traumatic events.

Results:
The interval from referral to diagnosis was not associated with psychological outcomes. A longer interval between diagnosis and TOP was associated with higher odds of prolonged grief disorder and depression at 4 months. The referral-to-TOP interval was associated with depression at 6 weeks only, with no association at 4 months or with prolonged grief disorder. Higher self-efficacy was associated with shorter decision-making intervals and more favourable psychological outcomes.

Conclusions:
Longer decision-making intervals following prenatal diagnosis of fetal anomalies are associated with adverse psychological outcomes after TOP. Self-efficacy may play a protective role and help identify individuals at risk.

P 88

Efficacy and safety of medical abortion at 10+1–12+0 gestational weeks: a retrospective cohort study

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Background:
Medical abortion accounts for 97% of all induced abortions in Sweden. Current regulations allow home administration of misoprostol up to 10+0 gestational weeks (GWs), whereas the World Health Organization (WHO) recommends self-managed medical abortion up to 12+0 GWs.

Objectives:
To evaluate the efficacy and safety of in-hospital medical abortion at 10+1–12+0 GWs and provide evidence relevant to a potential extension of home-based abortion in Sweden up to 12+0 GWs.

Methods:
A retrospective cohort study included all patients aged ≥18 years who underwent medical abortion between 10+1 and 12+0 GWs at Sahlgrenska University Hospital, between January 2020 and December 2025. Clinical data were extracted from electronic medical records.

Results:
No patient required blood transfusion. Acute vacuum aspiration was required in 20 patients (4.3%), including 12 patients (2.6%) with abnormal bleeding and 8 patients (1.7%) with retained products of conception, while 440 patients (95.7%) required no acute surgical intervention. Fourteen patients (3.0%) received intravenous fluids without further intervention. The median time from misoprostol administration to expulsion was 330 minutes (IQR 250-426). Higher parity was associated with shorter time to expulsion (adjusted HR 1.15, 95% CI 1.05–1.25, p=0.002). The median number of misoprostol doses administered was 2 (IQR 2-3). A total of 325 patients (70.7%) were managed with analgesia suitable for a home setting, including 205 (44.6%) who required no additional pain management beyond paracetamol and ibuprofen, and 120 patients (26.1%) received oral opioids.

Conclusion:
Medical abortion between 10+1 and 12+0 GWs in a hospital setting was safe and effective. Surgical intervention due to bleeding or retained products of conception was uncommon. These findings support extending access to home-based medical abortion up to 12+0 gestational weeks in Sweden and offering patients greater choice in their abortion care.

P 89

Pregnancy terminology in very early medical abortion

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Background:
The 2020 ESHRE recommendations on pregnancy terminology standardize early pregnancy description, crucially distinguishing normally sited from ectopic pregnancies. However, applying the suggested *early normally sited pregnancy* at very early medical abortion, i.e. abortion treatment before ultrasound confirmation of pregnancy location, is not always appropriate, as ESHRE's definition assumes diagnostic certainty when location cannot yet be confirmed.

Objective:
To identify ESHRE terminology limitations in context of very early medical abortion and propose terminology serving both obstetric and abortion care settings.

Methods:
Analysis of pregnancy categorization from a multicenter randomized study on very early medical abortions. Participants were stratified by ultrasound findings: pregnancy of unknown location, echogenic sac without fetal structures, visible yolk sac, or visible embryo. We compared ESHRE's current framework against ASRM's 2011 consensus definitions, evaluating how existing terminology describes very early intrauterine findings.

Results:
Echogenic sacs visible in the uterine cavity without definable fetal structures, common in very early medical abortions, does not fit ESHRE's definition of early normally sited pregnancy as this definition assumes pregnancies "have potential to develop normally." However, some of these pregnancies prove ectopic and the terminology conflates location with prognosis. The ASRM's "probable intrauterine pregnancy" better captures reality: it acknowledges ultrasound findings while explicitly admitting location uncertainty and avoids prognostic implications inappropriate for abortion care.

Conclusions:
ESHRE terminology excellently serves obstetric practice prioritizing location and viability confirmation. VEMA care involves different questions: probable location and appropriate treatment, not developmental potential. We propose terminology matching diagnostic certainty: pregnancy of unknown location (no sac), probably normally sited pregnancy (echogenic sac, unconfirmed location), and normally sited pregnancy (yolk sac/embryo visualized). This framework accommodates diverse clinicians with varying ultrasound expertise. As medical abortion before location confirmation expands globally, terminology supporting clinical appropriateness across settings becomes essential.

P 90

Medical abortion in adolescents in the Slovene Home environment

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Background:
Medical abortion (MA) enables pregnancy termination without surgery using mifepristone and misoprostol. Mifepristone, a progesterone antagonist developed in France in the 1980s, causes embryonic tissue detachment and cervical softening. Its efficacy is enhanced by misoprostol. MA was introduced in our institution in 2006, routinely implemented in 2007. Slovenia was included on the WHO-approved mifepristone list in 2013. Initially performed in hospital, MA was gradually transferred to the home environment following favorable clinical outcomes.

Objectives:
The study evaluated the occurrence, safety, complications, recurrence of MA among adolescents in northeastern Slovenia. We hypothesized that adolescents, due to good contraceptive counseling and easy access to contraception, would account for only a small proportion of abortions, and that home-based MA would not increase repeat abortions.

Methods:
This retrospective study included all adolescents undergoing MA up to 63 days of gestation between January 1, 2014, and October 31, 2025. Patients were divided into three age groups: <15 years, 15–17.9 years, and 18–19.9 years. The treatment regimen consisted of oral mifepristone (200 mg) followed 36–48 hours later by 800 µg of vaginal or oral misoprostol. Follow-up was performed in hospital initially and later in outpatient gynecology clinics. Descriptive statistical analysis was applied.

Results:
Among 4,487 MAs performed, 196 (4.4%) involved adolescents. Two patients were younger than 15 years, 69 were aged 15–17.9 years,125 were aged 18–19.9 years. Six patients (3.2%) underwent a repeat MA 5–20 months after the first procedure. One was younger than 17 years. The total number of adolescent patients was 190. All procedures were completed successfully without complications.

Conclusions:
Adolescents represented a small proportion of patients undergoing MA. The procedure was safe, without complications and a low repeat abortion rate. Continued contraceptive counseling, easy access to contraception, comprehensive sexual education remains essential for reducing unintended pregnancies.

P 91

Identifying priorities for reducing abortion stigma in the Australian healthcare workforce

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Background and Objectives:
Access to abortion in Australia is fragmented and inconsistent, with significant barriers. Stigma remains a key barrier to equitable, high-quality healthcare. Abortion stigma frames abortion as morally wrong and socially unacceptable and persists globally. Reducing abortion stigma in the health system is an urgent challenge aligned with human rights and public health priorities. This project aims to identify stigmatizing behaviors in healthcare that should be prioritized for targeting in future interventions.

Method(s):
Using interview data from abortion seekers in Australia, we engaged in an iterative analysis process to specify stigmatizing and non-stigmatising behaviours in healthcare settings that influence abortion experiences. We drew on behavior change theory and identified the actor, action, context, target, and time for each behavior. To complement abortion seeker perspectives, we designed an online survey to gather perspectives of people working in healthcare. The survey examined which behaviors in the healthcare workforce are most impactful on quality of care and most amenable to change.

Results:
We specified 31 stigmatizing and 22 non-stigmatising behaviors that could be reduced or encouraged to improve quality of care. These occur along the pathway to care: booking, referral, pregnancy options counselling, abortion service provision, and follow-up. Actors who may engage in these behaviors include receptionists, doctors, nurses, sonographers, and phlebotomists. Subsequent analyses will identify behaviors that are most impactful and feasible to target in developing interventions.

Conclusions:
These results, drawing on both abortion seeker and healthcare worker perspectives, can inform future interventions to reduce abortion stigma in healthcare settings. The findings highlight the importance of quality improvement efforts targeting specific behaviours along the pathway to abortion care.

P 92

Abortion self-care: revolution or unfinished promise? Lessons from IPPF's Global Membership

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Background:
Over the past decade, abortion self-care has emerged as a transformative approach to expanding access to safe abortion, particularly where legal, health system, financial, geographic, and social barriers limit facility-based care. Supported by growing evidence and the World Health Organization's Abortion Care Guidelines, self-care has been integrated into service delivery through telemedicine, pharmacy engagement, digital information, accompaniment models, and community-based support. Drawing on experiences from International Planned Parenthood Federation (IPPF) Member Associations, this abstract examines whether abortion self-care has fulfilled its promise to expand access and autonomy while identifying persistent barriers.

Objectives:
This abstract examines programme experiences across IPPF Member Associations to assess how abortion self-care has expanded access globally. It identifies successful implementation approaches, documents persistent barriers to equitable access, and explores emerging challenges that may limit future progress.

Methods:
The abstract draws on programme documentation, service data, implementation reports, and organisational learning from Member Associations across Africa, Asia, Europe, and the Americas, with particular attention to adolescents and young people, rural populations, sex workers, refugees and displaced populations, and LGBTIQ+ communities.

Results:
Between 2021 and 2025, abortion services delivered by Member Associations increased from 4,834 to over 96,652 annually (approximately 1,900%). Telemedicine, digital platforms, community-based support, and pharmacy-linked care improved privacy, convenience, continuity of care, and access for underserved populations, while ensuring service continuity particularly during COVID-19. However, restrictive laws, criminalisation, gestational limits, stigma, misinformation, medicine stock-outs, digital inequities, and growing opposition to abortion rights continue to limit access, particularly for marginalized populations.

Conclusions:
IPPF's experience demonstrates that abortion self-care has substantially expanded access, autonomy, and person-centred care but has not overcome structural inequities. Realising its full potential requires supportive legal and policy environments, reliable access to quality-assured medicines, investment in digital and community-based support, and targeted strategies to reach populations facing the greatest barriers.

P 93

Beyond distance: qualitative perspectives on remoteness and abortion care in Sweden

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Background:
Abortion access in Sweden is inequitably distributed, with substantial urban-rural disparities. Remoteness itself involves more than geographical distance. This study explores how remoteness influences abortion care and opportunities to improve it in rural and remote settings.

Objectives:
To explore how rurality and remoteness influence abortion access, experiences and decision-making from the perspectives of abortion patients and healthcare providers.

Methods:
Semi-structured interviews were conducted with 17 healthcare providers and 22 abortion patients from six Swedish regions with rural and remote populations (October 2025 – May 2026). Data were analyzed using reflexive thematic analysis.

Results:
Analysis yielded three themes. First, in "*Beyond distance"* participants described remoteness as strongly affecting abortion access, experiences, and decision-making through logistical challenges, privacy concerns, and increased uncertainty. These impacts were influenced by factors such as local healthcare accessibility, social support, medical history, and individual perceptions of remoteness, rather than geographical distance alone. Second, within *"Negotiating risk and responsibility"*, the absence of rural-specific abortion guidelines meant that healthcare providers relied on individual judgement when assessing suitability for home abortion. Several abortion patients felt they were expected to take on increased responsibility despite facing greater uncertainty. Third, within *"Adapting care to remoteness"*, participants described avoidable barriers arising from healthcare models that did not always accommodate the realities of remoteness and the specific requirements of abortion care. Participants suggested greater primary healthcare involvement, strengthened emergency preparedness, and expanded abortion care options.

Conclusion:
This study provides insights into how remoteness affects abortion care and informs practical adaptations to improve access and quality in rural and remote settings. The findings demonstrate that remoteness extends beyond geographical distance and is experienced through connectivity, local context, and the negotiation of responsibility. Improving equity requires healthcare models that strengthen connectivity and are adapted to the realities of remoteness and the specific needs of abortion care.

P 94

Identifying and responding to intimate partner violence in abortion care: perspectives from abortion care providers in Sweden

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Background:
Intimate partner violence (IPV) remains a serious global health issue. Given the association between IPV and abortion, abortion care may provide an important opportunity for intervention. Implementing sustainable IPV interventions requires consideration of societal, provider and organisational factors. This study explored abortion providers' perspectives and experiences of identifying and responding to IPV, the role of abortion care, and factors shaping this response.

Objectives:
To explore abortion providers' perspectives and experiences of identifying and responding to IPV within abortion care in Sweden.

Methods:
Semi-structured interviews were conducted with 21 abortion providers from seven Swedish regions (January – October 2025). Data were analysed using reflexive thematic analysis.

Results:
Analysis yielded three themes. First, in *"Moving towards universal IPV screening"*, participants considered universal IPV screening and creating a safe environment for disclosure as core professional responsibilities of abortion providers, given links between IPV, reproductive autonomy and seeking abortion. Beyond improving identification, universal screening was also described as reducing IPV-related stigma and bias and strengthening provider competence and IPV awareness. Second, within *"Defining IPV grey zones"* respondents described particularly non-physical forms of IPV as potentially difficult to identify due to often subtle manifestations, normalisation processes, and perceived "grey zones" in defining abusive behaviours. They therefore emphasised the importance of combining theoretical knowledge of IPV with practical experience in asking about it to facilitate meaningful disclosure. Finally, within *"Differences in organisational leadership condition the IPV response",* respondents described how variations in workplace prioritisation, education, and screening protocols influenced providers' confidence and consistency in enquiring about IPV.

Conclusion:
Abortion providers viewed abortion care as an important setting for IPV response, with routine enquiry considered essential. The findings highlight that implementing sustainable IPV interventions requires addressing provider knowledge, experience and professional role expectations, understanding IPV normalisation processes, and promoting organisational systems that prioritise and support IPV-related care.

P 95

Home-based follow-up after medical abortion using a low-sensitivity pregnancy test: a prospective multicentre study in Germany

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Background:
Routine follow-up after medical abortion in Germany is usually performed using ultrasound examination in a clinical setting. International evidence suggests that home-based follow-up using a low-sensitivity pregnancy test (LSPT) is a safe alternative, but prospective data from the German healthcare system have been lacking.

Objectives:
To evaluate the effectiveness, safety and acceptability of self-administered follow-up using an LSPT compared with routine ultrasound follow-up after medical abortion.

Methods:
We conducted a prospective, multicentre, partially randomised patient preference study in 11 German abortion care centres between March and September 2024. A total of 312 participants were enrolled. Women with a strong preference for one follow-up method selected their preferred option, while those without a preference were randomised to home-based follow-up using an LSPT (1000 mIU/mL) or routine ultrasound examination. The primary outcome was the detection of ongoing pregnancy. Secondary outcomes included complications, test performance and patient satisfaction.

Results:
All ongoing pregnancies were correctly identified, resulting in a sensitivity of 100% in both follow-up groups. Specificity was 92.7% for the LSPT and 100% for ultrasound. Complications were uncommon and occurred at similar rates in both groups. Discordant results were infrequent and were mainly attributable to false-positive LSPT results with faint test lines close to the detection threshold. Satisfaction with follow-up remained high in both groups, although it was slightly lower among participants using the LSPT (85.9% vs. 98.3%). Perceived safety was high regardless of follow-up method.

Conclusions:
Home-based follow-up using an LSPT is a safe and well-accepted alternative to routine ultrasound after medical abortion. This approach may reduce unnecessary clinic visits while maintaining patient safety and has the potential to improve access to high-quality, person-centred abortion care, particularly for people living in underserved or remote areas.

P 96

Additional number of doses of misoprostol needed to evacuate a uterus using misoprostol-alone regimen before 12 weeks of gestational age: a systematic review

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Background:
Misoprostol-alone regimens are particularly important in settings where mifepristone is unavailable or inaccessible for abortion. Current WHO guidance recommends no maximum dose to define a failed abortion before 12 weeks' gestation, yet providers and users require evidence-based guidance on the matter.

Objectives:
To evaluate the number of misoprostol doses required to evacuate the uterus in patients undergoing medical abortion up to 12 weeks' gestation

Methods:
We conducted a systematic review using Cochrane methodology. We searched PubMed, Embase, Cochrane Central Register of Controlled Trials, Global Index Medicus, the International Clinical Trials Registry Platform, and Popline from database inception to June 2026. Eligible designs included randomised controlled trials (RCTs), non-randomised trials, and observational studies. We included studies of abortion or miscarriage to 12 weeks of gestational age using misoprostol-alone regimens with 800 mcg as the first dose, via any route or interval, with a comparison group. Primary outcomes were successful abortion, ongoing pregnancy, incomplete abortion, additional doses needed, time to completion, hemorrhage, infection, surgical intervention, hospitalization, uterine rupture, venous thromboembolism, and death. Secondary outcomes were pain, gastrointestinal side effects, patient experience, and contact to healthcare provider. Two reviewers independently completed title and abstract screening and full-text review, with disagreements resolved by consensus. We assessed risk of bias using the Risk of Bias-2 and ROBINS-I tools. Data extraction and meta-analysis are ongoing.

Results:
We identified 2,138 unique records and four studies met inclusion criteria. One study was an RCT, one a mixed design, and two were observational cohort studies. Included studies enrolled a combined total of 1755 participants. Detailed data extraction and synthesis are currently underway.

Conclusions:
This is the first systematic review to address the number of misoprostol doses required for abortion before 12 weeks' using a misoprostol-alone regimen. Findings will inform WHO Abortion care guidelines and clinical practice

P 97

Beyond legal access: preliminary findings from the first Dutch multidisciplinary telemedical abortion platform

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Background:
The Netherlands is widely regarded as having highly accessible abortion care through specialized clinics and, since 2025, through general practitioners providing medical abortion.

Objectives:
However, legal availability does not necessarily ensure equitable access in practice. On 23 March 2026 Thuisabortus.nl was launched as the first Dutch multidisciplinary telemedical abortion platform, bringing together general practitioners, gynecologists and midwives to provide abortion care up to 9 weeks' gestation.

Methods:
To describe the characteristics and experiences of individuals receiving care through Thuisabortus.nl and explore whether telemedical abortion addresses needs not fully met by existing abortion care.

Results:
We conducted a retrospective analysis of routinely collected clinical data and patient evaluation questionnaires from individuals receiving care through Thuisabortus.nl during its first months of operation. Clinical data included age, residential postcode and gestational age. Questionnaires assessed treatment outcomes, healthcare utilization, satisfaction with care. Free-text responses were reviewed for recurring themes
Since its launch, Thuisabortus.nl has provided care to an average of 75 individuals per week, representing one-quarter of all medical abortions provided nationally during the same period. High levels of satisfaction and limited post-treatment healthcare utilization were registered. Free-text responses suggested that travel burden, physical limitations, privacy concerns and previous negative healthcare experiences influenced some individuals' choice for telemedical care. Notably, 10% of respondents reported they would not have obtained an abortion had telemedical abortion not been available.

Conclusion:
The rapid and sustained uptake of the Thuisabortus.nl platform suggests that telemedical abortion meets needs not fully addressed by existing care pathways. As part of a broader abortion care landscape, telemedical services may complement clinic- and GP-based care by increasing choice and enabling individuals to access care that suits their circumstances and preferences. The multidisciplinary team behind the platform represents collaboration across traditionally separate professional domains and may contribute to more integrated, accessible and patient-centered abortion care.

P 98

Medical abortion as a feminist practice. The case of the French AD93

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Background:
In 2005, the Departmental Association 93 (AD 93) of the Mouvement Français pour le Planning Familial became the first family planning centre in France to offer medical abortion. In partnership with the Seine-Saint-Denis City-Hospital Network, set up an experimental program aimed at guaranteeing access to this method.

Methods:
Thanks to in-depth interviews and participant observation, this contribution reconstructs how the AD 93 experience marked a decisive step forward in access to abortion in France. It also seeks to analyse how this access is still supported and accompanied today within the association by a feminist practice dating back to the 1960s, namely the “collective welcome” (accueil collectif).
The “collective welcome” is a form of abortion support which is a space of physical proximity, exchange, and mutual aid for people who are about to undergo an abortion. These moments are essential to the abortion process and provide an opportunity to create a sisterhood^{+} that challenges the experience of the clinical setting, generally perceived as distant, and impersonal.

Results:
Abortion at AD 93 is thus characterized by a collective dimension that involves both service users and the centre’s staff. Medical and non-medical personnel participate jointly in the process. This reinforces a demedicalised perspective on abortion, offers multiple viewpoints on users' situations, and ensures constant support among colleagues. These conditions enable the practice of “systematic screening” to detect situations of violence, thereby fostering feminist care practices against patriarchal violence.

Conclusion:
This case study presents the possibility of a form of abortion that is not rooted in a strictly individual logic but asserts itself as a practice that is both collective and political, thanks to the promotion of innovations such as the option of having an abortion in an outpatient setting, and through the maintenance of feminist traditions of horizontal transmission of knowledge related to the body/bodies.

Pain and Risk Management

P 99

Patient experiences of pain and anxiety during abortion procedures under conscious sedation up to 17+6 weeks' gestation

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Background:
Conscious sedation (CS) is an anaesthetic option for patients undergoing surgical abortion that reduces pain and anxiety while the patient remains awake. Research on patient experience of CS during abortion procedures is limited.

Objectives:
To understand patient experiences of abortion procedures under CS up to 17+6 weeks' gestation.

Methods:
Between 06/06/2025 and 25/08/2025, we invited patients undergoing surgical abortion under CS at an independent abortion provider in England and Wales to complete a post-procedure experience survey. Pain was reported on a 10-point scale and grouped in analysis as low (0–3), moderate (4–6), and high (7–10). Anxiety was reported on a 5-point Likert scale from none to extreme. Satisfaction was measured on a 10-point scale. Descriptive statistics were calculated in STATA.

Results:
382 respondent surveys were collected and 294 were complete and included in the analysis. Mean age was 27 years (15–46), 52% White British, and 79% had a pregnancy duration of ≤13+6 weeks', with 8% between 14–17+6 weeks'.
Most (94%) reported a degree of anxiety before their procedure. During, 50% reported some or moderate anxiety and 26% none. After, most (68%) were not anxious. Most reported low levels of pain before (75%) and after (70%) their procedure. During, 48% reported low, 37% moderate, and 15% high levels of pain. Pain during treatment appeared associated with higher pregnancy duration, with 29% reporting high pain at 14–17+6 weeks' versus 12% at ≤13+6 weeks'.
Average satisfaction score was 9.2 out of 10. Patients with lower satisfaction (1–3) did not feel sedated enough and experienced more pain than expected.

Conclusions:
CS decreases self-reported pain and anxiety for many during surgical abortion up to 17+6 weeks' and satisfaction scores are high. Future research should explore ways to reduce variation in pain and anxiety with procedures under CS.

P 100

Reliability of ultrasound criteria of probable intrauterine pregnancy in predicting intrauterine pregnancy in those seeking abortion who have symptoms and/or risk factors for ectopic pregnancy.

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Background:
Increasingly, women are presenting for abortion at gestations <6 weeks, when the first sign of a definitive intrauterine pregnancy (IUP)- a yolk sac- cannot yet be visualized on ultrasound. We have previously demonstrated that patients meeting 'strict' ultrasound criteria of a probable IUP (eccentrically placed gestation sac ≥3mm, with a decidual reaction) can be managed safely with immediate medical abortion with routine follow-up at 2 weeks. However, this only applies to those *without* symptoms/risk factors for ectopic pregnancy and data on whether these criteria could also be used to safely provide immediate abortion to those who do, is lacking.

Objectives:
To assess the reliability of ultrasound criteria of probable IUP in excluding ectopic pregnancies in those presenting for abortion with symptoms/risk factors.

Methods:
A single-site retrospective review of cases of ultrasound-defined probable IUPs with symptoms/risk factors for ectopic over a 5-year period from April 2020- December 2025 was conducted, using electronic patient record systems and our prospectively collected abortion database. The primary outcome was cases of ectopic pregnancies, not identified at baseline. The secondary outcome was complete abortion rates.

Results:
151/1686 (9%) patients met all the ultrasound criteria for a probable IUP. None of these 151 patients had an ectopic pregnancy. 144/151 (95%) ultimately proceeded with medical abortion and one patient had a surgical abortion. The remaining six patients did not have abortion treatment, due to either miscarrying or continuing the pregnancy. Of the 144 patients having medical abortion, the complete abortion rate was 99% (n=143/144) with one patient requiring surgical management for incomplete abortion.

Conclusions:
Our 'strict' ultrasound criteria of probable IUP should reasonably reliably exclude an ectopic pregnancy even in the presence of symptoms/risk factors. Protocols should be adapted to allow women who meet these ultrasound criteria to proceed immediately with medical abortion.

Second Trimester and More

P 101

Safe abortion accompaniment in crisis-affected regions of Cameroon: Second trimester regimen

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Background:
Cameroon has high maternal mortality, with unsafe abortion causing 23% of deaths. In crisis-affected regions, over 2.1 million people are displaced, and women often seek second-trimester care late due to restrictive laws, stigma, and weak health systems.

Objectives:
To identify how abortion accompaniment works for second-trimester clients in conflict-affected Cameroon and determine lessons for designing sustainable models that reduce maternal morbidity and mortality.

Methods:
Qualitative descriptive study in North-West, South-West, and Far North (hard-to-reach areas). Target population: hotline counsellors, community service providers, and programme staff. Sample size: 86 anonymised case narratives, 13 staff debriefings, programme records. Purposive sampling. Data collection: case documentation and reflective transcripts. Analysis: thematic analysis (pathways to care, risk management, ethical dilemmas, staff burdens). Ethical considerations: anonymisation, informed consent, do-no-harm review. Inclusion: second-trimester cases; exclusion: first-trimester.

Results:
Thematic analysis identified layered accompaniment (counselling, risk assessment, transport, referrals) as effective for helping clients avoid unsafe providers and reach facilities with medical/surgical capacity. Clients had fewer severe complications than expected. Staff reported threats, moral distress, and burnout due to missing security protocols and psychosocial support. Key themes: need for risk checklists, referral agreements, debriefings, and escalation pathways.

Conclusions:
Community accompaniment creates safer pathways for second-trimester abortion in crisis settings but requires dual-protection for clients and staff. Simple tools and protocols can be adapted to reduce abortion-related mortality.

P 102

Abortion care after 24 weeks: expanding access, advancing practice

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Background:
Access to abortion care after 24 weeks' gestation remains limited despite increasing need. Contributing factors include delayed diagnoses, structural barriers, a shortage of trained providers, and evolving legal landscapes. Clinical practice varies widely, and there is limited comparative evidence to guide optimal approaches.

Objectives:
To review existing evidence and emerging clinical practices for abortion after 24 weeks' gestation and to describe key components of care for safely expanding services across clinic and hospital-based settings.

Methods:
We conducted a narrative review of published literature and single-center studies and synthesized emerging clinical guidance along with experiential data from outpatient and hospital-based providers. Care models were categorized into three primary approaches: dilation and evacuation (D&E), medication abortion (induction), and induction–evacuation.

Results:
All three care models are effective, although comparative outcome data are limited. Medication abortion typically involves mifepristone followed by misoprostol and/or oxytocin within a hospital-based facility. D&E relies on cervical preparation with osmotic dilators and adjunctive medications. Induction–evacuation combines cervical preparation with labor induction prior to instrumented evacuation. Inducing fetal asystole before cervical preparation is considered best practice to prevent unintended expulsion with cardiac activity. Reported complication rates are low across approaches in the clinic setting, with hospital transfer rates <0.5% among patients without prior cesarean delivery and approximately 1.5–2% among those with prior cesarean delivery. Adjunctive practices—including universal antibiotic prophylaxis, multimodal analgesia, and routine use of cabergoline for lactation suppression—improve outcomes and patient experience.

Conclusions:
Abortion care after 24 weeks is safe and can be provided using multiple approaches tailored to provider expertise and clinical setting. Significant gaps remain in comparative effectiveness data. Expanding access requires not only technical capacity but also a strong emphasis on patient-centered care, including emotional support, team-based culture, and reduction of financial and structural barriers.

P 103

Abnormal coagulation studies and bleeding complications in second-trimester fetal demise

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Background:
Fetal demise in the second trimester is rare. Historically, prolonged retention of a demised fetus has been associated with coagulation abnormalities.

Objectives:
To estimate the incidence of coagulation abnormalities and bleeding complications in second-trimester intrauterine fetal demise (IUFD); to determine whether prolonged demise duration increases the risk of abnormal coagulation studies and bleeding.

Methods:
We conducted a retrospective cohort study among patients scheduled for dilation & evacuation (D&E) with a fetal demise measuring 12 weeks and over. Patients had coagulation studies drawn preoperatively and we measured demise duration based on the discrepancy between ultrasound measurements and gestational age by dates. We calculated 95% Wilson confidence intervals for proportions. We used the Chi Squared test to compare proportions across groups and calculated risk ratios using log-binomial regression. We used simple linear regression to examine the association between continuous outcomes. We conducted analyses using Stata SE Version 16.0, setting the level of significance at 5%.

Results:
A total of 219 met criteria for inclusion in the study. Of these, 28/193 with available preoperative coagulation studies had abnormal results (14.51%, 95% CI 10.23-20.17). Low fibrinogen was the most common abnormal coagulation study (25/28 abnormal values), and five patients with low fibrinogen had bleeding complications, four of which occurred postoperatively. Demise duration >29 days was the only variable associated with abnormal coagulation studies (RR 2.41, 95%CI 1.27-4.84). For each additional day of demise, average fibrinogen levels decreased by 1.8 mg/dL (p=0.0013, R^2 =0.057). Of the 215 patients who could be assessed for bleeding, 28 had complications (15.35%, 95%CI 11.11-20.77). Demise duration > 29 days was associated with bleeding (RR 2.15. 95%CI 1.06-3.71), as was prior cesarean delivery (p=0.023).

Conclusion:
Prolonged duration of demise is associated with low fibrinogen and bleeding complications, including delayed hemorrhage. Patients with second-trimester IUFD require prompt uterine evacuation.

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Manual uterine Aspiration between 13.0 and 14.6 weeks of gestation: clinical characterization, surgical technique, and immediate safety. A cross-sectional descriptive study in Profamilia Colombia, 2020–2024

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Background:
Manual uterine aspiration (MUA) is recommended for uterine evacuation through 14 weeks of gestation; however, evidence supporting its safety and feasibility beyond 12 weeks remains limited in Colombia. Despite Constitutional Court Ruling C-055 of 2022, dilatation and curettage (D&C) continues to be widely used, creating a gap between international recommendations and clinical practice.

Objectives:
To describe the sociodemographic characteristics, surgical technique, and immediate safety outcomes of MUA performed between 13.0 and 14.6 weeks of gestation at Profamilia Colombia clinics between 2020 and 2024.

Methods:
A cross-sectional study was conducted using secondary data from institutional records of MUA procedures nationwide. Sociodemographic, obstetric, and procedural variables were analyzed using descriptive statistics, Spearman correlation, Mann-Whitney test, chi-square, and binary logistic regression.

Results:
A total of 671 procedures were analyzed. Median gestational age was 13.4 weeks, and mean patient age was 25.0 years. All procedures were performed under paracervical block with lidocaine; a two-point block was used in 91.8% of cases, and Denniston dilators were used in all procedures. Maximum dilator size was positively correlated with the number of paracervical block points (Spearman rho = 0.322; $p < 0.001$). Logistic regression identified maximum dilator size (adjusted OR 3.31; 95% CI 1.99–5.50), primary cannula caliber (OR 1.85; 95% CI 1.22–2.80), and gestational age (OR 2.16; 95% CI 1.12–4.18) as independent predictors of requiring a four-point block. 98.1% of procedures were completed without complications and no uterine perforations or cervical injuries occurred.

Conclusions:
MUA between 13.0 and 14.6 weeks of gestation is a safe, technically feasible ambulatory procedure under paracervical block using equipment available in gynecological services. These findings provide evidence supporting broader implementation of MUA in this gestational range and contribute to closing the gap between international recommendations and Colombian clinical practice while expanding access to safe, and person-centered abortion care.

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How many dilatation and evacuation cases are needed to attain competence?

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Background:
In the US, since 1996, the Accreditation Council for Graduate Medical Education requires all obstetrics and gynecology (ob-gyn) residency programs to include routine abortion training as a dedicated, scheduled rotation. In the US, abortion training includes dilatation and evacuation (D&E). The Ryan Program, a national organization that supports abortion training in ob-gyn residency programs, collects evaluation data from these programs.

Objectives:
Because it is not clear whether there is a minimum number of D&E procedures needed to be ready to provide independent, unsupervised care, we explored correlations between D&E numbers and readiness for independent practice, from faculty and trainee perspectives. These data might help training programs establish expectations and resources for training to competence in D&E.

Methods:
The Ryan Program collects post-rotation data from residents at each residency program, including number of D&Es done and perceptions of readiness to provide D&E in practice. Family planning faculty are also surveyed annually including about number of D&Es done by residents and what proportion of residents is ready for independent practice in D&E at specific gestational ages at graduation. In 2025, the faculty survey included questions about the numbers of D&E cases residents required before achieving competence. We report on the association between case numbers and readiness for practice.

Results:
Among 699 residents who completed post-rotation surveys (response rate 72%), 60% considered themselves ready for independent practice to provide D&Es to 18 weeks' gestation or above. The proportion ready for independent practice to 18 weeks was correlated with increasing numbers done, with 67% and 97% reporting readiness among those who had done 11-20 procedures and more than 20 procedures, respectively. Faculty reported that the mean number of D&Es done by residents was 35 (median 25, range 0-100) and that their residents were trained to an average of 17 weeks' gestation (range 14-24). Of 97 faculty (response rate 84%), 71% considered most residents competent in D&E to 18 weeks' gestation post-rotation. Most faculty at programs where, on average, residents did 11-20 D&Es (82%) and more than 20 D&Es (88%) considered most of their graduating residents to be competent to 18 weeks post-rotation. Faculty reported that the average number of procedures required to be considered competent to 18 weeks' gestation was 15 (median 15, range (5-30); when considering individual residents, they reported that the fewest numbers done by individual residents before achieving competence was, on average, 8.8 (median 10, range (2-25), and the highest numbers done by individual residents needed before achieving competence was, on average, 18.9 (median 20, range (8-50).

Conclusions:
Almost all US ob-gyn residents reported readiness for independent practice to 18 weeks with twenty cases done, and most program directors confirmed that most residents achieved competence with this volume. Directors also reported that individual residents sometimes need fewer or more to achieve competence. D&E competence should be assessed at an individual level rather than a case number requirement.

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Uterine rupture risk after second-trimester medical abortion among women with previous caesarean section: a retrospective cohort study

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Background:
Uterine rupture is a rare but serious complication of second-trimester medical abortion, particularly in individuals with a history of caesarean section (CS). In Sweden, 97% of all second-trimester abortions are medical abortions. Existing studies using comparable protocols include few patients with prior CS, limiting conclusions about this potentially life-threatening complication.

Objectives:
To quantify the risk of uterine rupture, haemorrhage, surgical intervention and compare abortion progression in patients with and without a history of CS undergoing second-trimester medical abortion using the Swedish mifepristone-misoprostol regimen

Methods:
This retrospective cohort study includes 1257 patients undergoing medical abortion between gestational weeks 12+1 and 21+6 at Sahlgrenska University Hospital, Gothenburg, Sweden, from January 1, 2021 to December 31, 2025. The regimen consisted of oral mifepristone 200 mg, followed 24–48 hours later by vaginal misoprostol 0.8 mg then 0.4 mg every three hours until expulsion. If abortion was not completed within 24 hours, mifepristone was repeated. Prolonged cases received a cervical ripening balloon. Statistical analyses included Mann-Whitney U, Kruskal-Wallis, chi-square and Fisher's exact tests.

Results:
Overall, 687 (54.7%) were parous and 158 (12.6%) had a history of CS. The median age was 32 years (range 18–48). One uterine rupture (0.08%) occurred in a patient with two prior CS. Eleven patients (0.9%) required blood transfusion and 126 (10.0%) underwent acute surgical intervention (vacuum aspiration or manual removal of placenta). Two patients (0.2%) underwent hysterectomy within seven days, one due to uterine rupture. Need for surgical intervention did not differ by CS history. However, haemorrhage >500 mL was more common in patients with prior CS (15.9% vs 9.4%, $p = 0.01$).

Conclusions:
Second-trimester medical abortion using the standard Swedish regimen appears safe in patients with a prior CS. Larger multicentre or prospective studies are needed to confirm those findings and identify patients requiring closer monitoring.

P 107

Surgical termination of pregnancy in Germany beyond the first trimester

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Background:
International evidence demonstrates clearly that surgical termination of pregnancy (TOP) in the second trimester is a safe procedure that is often preferred by patients over medical inductions. Despite this evidence and the established use of surgical TOP in many countries, second trimester TOP in Germany is still predominantly performed using medical methods.

Objectives:
The aim of this study was to show that surgical termination of pregnancy using established surgical treatment methods (D&A, D&E) is possible and safe in a regular German hospital setting and that rates of complication are comparable to those reported in international literature.

Methods:
Between May 1, 2023, and December 31, 2024, data for this retrospective monocentric cohort study was collected in a hospital in Berlin Kaulsdorf. All patients seeking TOP were offered standardized treatment options according to gestational age. Patient characteristics, treatment methods, gestational age, and complications were retrospectively analyzed.

Results:
A total of 152 patients were included in the analysis, about 31 (n = 47) presented during the first trimester, roughly half of the study cohort (n = 69, 46%) in the early second trimester and 35 women (23%) presented in the late second trimester, after 19 weeks of pregnancy. Complication rates over all treatment options and gestational age groups were low, complications occurred in only 13 cases (9%), with one severe complication.

Conclusions:
This study demonstrates that surgical termination of pregnancy can be safely and successfully implemented in a routine German hospital setting, with complication rates as low as reported in international literature, including the second trimester. The continued limited availability of second trimester surgical TOP in Germany therefore does not appear to be related to safety or feasibility concerns. Instead, further efforts are needed to address and investigate structural barriers to implementation.

Statistics

P 108

Assessing the causal relationship between abortion restrictions and maternal morbidity and mortality: applying the Bradford-Hill Criteria to a systematic review of the literature

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Background:
Identifying the causal relationship between abortion restriction and maternal morbidity and mortality has important public health, reproductive justice, and policy reform implications. The Bradford-Hill Criteria (BHC) provide a framework to organize existing research and assess for evidence of a causal relationship between an exposure and an outcome. BHC are particularly useful on contentious topics, to exert evidence on the harms of an exposure that cannot ethically be tested with randomized controlled trials.

Objective:
This systematic review aims to collate and analyze the body of literature investigating the association between abortion restriction and maternal morbidity and mortality throughout the world. Specifically, this review employs the novel approach of applying the nine BHC to determine whether the existing evidence supports a causal relationship between abortion restrictions and maternal morbidity and mortality.

Methods:
PubMed, Embase, Scopus, and Web of Science electronic databases were searched for publications describing or evaluating the association between abortion restriction and maternal morbidity and mortality through May 2024. Abstracts were reviewed to determine relevance and data were extracted including study design, interventions, outcome measures, and results. A narrative synthesis of key results was performed using the BHC as a framework.

Results:
Initial search yielded 873 publications, 77 of which were deemed relevant. All nine BHC – strength of association, consistency across studies, specificity, temporal sequence, dose-response relationship, biological plausibility, coherence, experimental evidence, and analogy – were met by the preponderance of the evidence. However, the strength of association was moderate with relative risk greater than 1.0 but less than 2.0 for all studies reviewed. Conclusions: Using the BHC to assess causality, this systematic review of existing literature provides moderate, consistent, specific evidence to support the hypothesis that a causal relationship exists between abortion restriction and maternal morbidity and mortality.

P 109

Beyond retrospective estimates: piloting online search analysis as a low-cost, real-time measure of abortion demand

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Background:
Understanding global abortion demand traditionally relies on large-scale, resource-intensive, retrospective studies. Abortion programs use these data to allocate resources, sometimes on figures that are years old. As health-seeking behaviour moves increasingly online, [OUR ORGANIZATION] tested whether online abortion searches could serve as a real-time proxy for abortion demand as a complementary approach to traditional techniques.

Objectives:
[OUR ORGANIZATION] piloted an approach to estimate abortion demand across 24 countries through analysis of Google search data. Building on existing keyword analysis experience and collaboration with a US-based research lab, we tested whether care-seeking intent could be reliably isolated from non-care-seeking searches and assessed the reliability of commercial SEO platform estimates (Semrush) against Google Trends data.

Methods:
A retrospective digital behaviour analysis was conducted across 24 countries over 12-months (May 2025-April 2026). Countries were selected based on internet penetration and literacy, with a focus on Global South settings where traditional demand data is most limited. Using AI-driven text clustering, queries were filtered to isolate direct care-seeking intent - including medication and sourcing inquiries, logistical lookups, safety evaluations, and localised colloquialisms. Educational, media, and political search terms were excluded. Semrush volume estimates were cross-validated against Google Trends.
Results. The study mapped 4.90 million direct care-seeking queries across the 24 countries. Excluding politically-influenced spikes, care-seeking searches were relatively stable across 12 months. Cross-validation against Google Trends revealed technical anomalies in Semrush estimates - including implausible country-level drops.

Conclusion:
Targeted analysis of online abortion search behaviour can produce a proxy estimate of abortion demand, with care-seeking intent separable from educational and political noise. Commercial search tools require cross-validation, and the model will need ongoing refinement to capture evolving search behaviour - including growing use of LLM-based tools - and shifting local terminology. This approach shows promise as a low-cost, real-time complement to traditional abortion demand estimation methods

P 110

Rise in second trimester abortions after increased access to abortion in Norway – women's choice or reduced access?

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Background:
In 2024 Norway reformed its abortion law from 1975. It came into effect June 1st, 2025. Access to abortion on request increased from 12 weeks (11+6; crown-rump-length (CRL) maximum 66mm) to 18 weeks (17+6). Beyond and up to 22 weeks an abortion can be granted by a commission. Beyond 22 weeks an abortion can only be performed if the woman's life and health is at acute risk or if the fetus is non-viable.

Objectives:
Prior to law reform, one concern was that abortions after 12 weeks would increase. the Abortion Registry has received concerns over possible increased waiting times for abortions independent on gestational length. We aimed to use data from the national Abortion Registry to obtain country-wide information on waiting times and address these concerns.

Methods:
The Abortion Registry includes anonymizeddata from all abortions in Norway. The data set includes data on gestational length at abortion, but no data on waiting times. We analyzed data from prior to the abortion law reform and after using gestational age at the time of the abortion as an indirect measure of changes in access to abortion or as changes in women's behavior.

Results:
Over the last 25 years about 90% of women had their abortion within the first 10 gestational weeks, with a span from 91.2% in 2020 to 89.0% in 2025. In 2025 5.4% had a second trimester abortion before June 1st and 5.9% after legal changes. Seasonal variety before and after June 1st was found in the previous years also.

Conclusion:
We have several possible explanations for the increase in second trimester abortions. 1. A relative increase due to CRL 66 being defined as 13 weeks under the new regulations. 2. Increased waiting time. 3. Women wait longer of their own will or 4. Random seasonal trends.

Surgical Abortion

P 111

Safety of conscious sedation for abortion up to 17+6 weeks of gestation: a 5-year service evaluation

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Background:
General anaesthesia (GA) is not routinely recommended for early surgical abortion. Moderate (conscious) sedation (CS) with intravenous fentanyl and midazolam is an alternative to GA or local anaesthesia in first and early second trimester.

Objectives:
To explore clinical outcomes of surgical abortion performed under CS up to 17+6 weeks' gestation. To document the incidence of sedation-related complications; 2) To compare surgical complications between CS and GA procedures.

Methods:
We retrospectively analysed outcomes of all surgical abortions to 17+6 weeks' gestation performed under CS and GA at an independent abortion provider in the United Kingdom from 01/01/2020 to 31/12/2024.
We estimated sedation and surgical complication rates during treatment (immediate) and post-discharge (delayed), rate ratios (IRRs), and 95% confidence intervals using Poisson methods. We defined statistical significance as $p < 0.05$.

Results:
There were 26,237 abortions under CS and 16,832 under GA. Eighty-one sedation-related complications were recorded (0.31%) in 60 patients (0.23%). Reversal drugs were administered in 8 cases (0.03%), 2 of which (0.01%) had a sustained drop in oxygen saturation below 90%. All responded to pharmacological reversal without need for airway instrumentation or further intervention. The most common sedation-related complication was inability to complete the procedure (0.08%, n=20).
There were 244 surgical complications under CS (0.93%) and 51 under GA (0.30%); IRR 2.19, 95% CI 1.66–2.83, p=< 0.001.
Immediate complications were 58 for CS (0.22%) and 17 (0.10%) for GA; delayed were 186 (0.71%) for CS and 34 (0.20%) for GA.
Haemorrhage was the most frequent immediate complication: CS - 0.13% (n=33); GA - 0.06% (n=11). The incidence of haemorrhage requiring blood transfusion was the same (0.03%).

Conclusions:
Surgical abortion up to 17+6 weeks' gestation under CS has a low rate of sedation-related and surgical complications. Comparison of surgical complications between CS and GA procedures warrants further prospective studies.

Unsafe or Safe Abortions

P 112

Integrating trace data to monitor abortion safety in restrictive settings

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Background:
In Cameroon, legally restricted abortion occurs largely outside formal facilities, making unsafe procedures a major but invisible contributor to maternal harm. Hotlines, pharmacies, and accompaniment services collect rich data streams that remain fragmented and under-analysed.

Objectives:
To identify how traditional and digital trace data can improve abortion safety monitoring and inform community-governed, rights-affirming data systems.

Methods:
Qualitative descriptive study across hotlines/accompaniers, facility providers in urban/rural districts, and SRH civil society organisations. Data included documentation of data flows, 28 key informant interviews, and digital tool inventories. Thematic analysis examined data traces, integration barriers, and ethical/security considerations.

Results:
Multiple underused streams: hotline logs, informal referrals, pharmacy abortifacient sales, narrative cases, could reveal patterns of unsafe methods, delayed care, and provider refusals if aggregated. Fragmentation stemmed from legal fears, inconsistent indicators, and lack of secure platforms. Participants prioritised anonymisation, local governance, and separation from state surveillance. Prototype community abortion safety observatory demonstrated feasibility of minimal, de-identified indicator linkage.

Conclusions:
Community-governed trace data integration offers practical visibility into hidden abortion harm patterns while protecting vulnerable actors. Shared data dictionaries, secure channels, and ethical protocols enable replication in restrictive settings, supporting targeted interventions, advocacy, and accountability for safe abortion access.

P 113

Evolving agency and autonomy among IDPs seeking safe abortion in Cameroon

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Background:
Cameroon's conflicts have displaced over 2 million people, increasing risks of sexual violence, unintended pregnancy, and unsafe abortion for adolescent girls and young women. Restrictive laws and stigma limit options.

Objectives:
To identify how agency and autonomy evolve during abortion decision-making among internally displaced women and adolescents and determine accompaniment strategies that expand decision space without increasing harm.

Methods:
Qualitative study in two conflict-affected regions. Target population: IDP women/adolescents who sought abortion services. Sample size: 32 in-depth interviews with IDPs (past 18 months), 18 with service providers. Purposive sampling. Data collection: timeline-based interviews. Analysis: thematic analysis (information flows, gatekeepers, risks, self-assertion). Ethical considerations: informed consent, anonymity, trauma-sensitive approach. Inclusion: IDPs aged 15+ seeking abortion; exclusion: non-IDPs.

Results:
Thematic analysis showed abortion decisions as cumulative processes shaped by armed groups, camp rules, family surveillance, and resource access. Constraint themes: violence threats, denunciation, moral pressure. Agency themes: strategic secrecy, peer planning, negotiation with accompaniers. Rights-based accompaniment (information, method options, safety planning) increased autonomy; rigid/moralising approaches narrowed choices. Adolescents used peer networks and hotlines effectively.

Conclusions:
Agency among IDPs is negotiated, not absent. Accompaniment treating women as co-strategists expands autonomy and safety but must address displacement-specific risks.

P 114

Accuracy of history-based assessment of gestational length in telemedicine abortion, utilizing data from a randomised controlled trial

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Background:
Accurate estimation of gestational length is essential for early medical abortion, particularly in telemedicine models without routine ultrasound. Evidence from randomised comparisons between telemedicine and standard care is scarce. We evaluated history-based gestational length estimation against ultrasound in a randomised trial.

Methods:
This analysis of secondary outcomes included 1,323 participants from a multicentre randomised trial comparing telemedicine with standard medical abortion. Women ≥18 years requesting home medical abortion at ≤9 weeks gestation by self-assessment were eligible. Inclusion required ultrasound data and history-based gestational length (LMP or own estimate). Logistic regression compared misclassification ≥14 days between groups and identified associated factors. A threshold analysis assessed probability of exceeding Sweden's home abortion limit (70 days).

Results:
Overall, 94.4% accurately self-estimated gestational length. Mean differences compared with ultrasound were small (1.8 days for LMP and combined measure; −1.8 days for women's own estimate). Underestimation was more frequent in telemedicine (2.6% vs 0.8%; OR 3.5, 95% CI 1.28–9.37). Irregular cycles (aOR 2.44, 95% CI 1.35–4.41) or uncertain regularity ("does not know") (aOR 4.24, 95% CI 1.68–10.72) and estimated rather than known LMP (aOR 2.94, 95% CI 1.62–5.32) were independently associated with misclassification when adjusted for age, parity, previous abortion, menstrual regularity, hormonal contraception at conception, certainty of LMP and randomisation group. The probability of exceeding 70 days when classified as ≤70 days by history was <1%.

Conclusions:
History-based gestational length estimation showed small differences compared with ultrasound and low misclassification rates, with similar accuracy in telemedicine and standard care. Structured menstrual history supports selective rather than routine ultrasound use in low-risk populations

P 115

Expanding person-centered abortion care in Francophone West and Central Africa: lessons from the SCAAO Initiative (2023–2025)

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Background:
Access to safe, person-centered abortion care in Francophone West and Central Africa remains constrained by restrictive laws, stigma, and health system limitations. To address these barriers, the multi-country initiative *Soins Centrés sur l'Avortement en Afrique de l'Ouest et du Centre* (SCAAO) led by IPPF was implemented from 2023–2025 in Togo, Cameroon, and Niger, with regional leadership from Burkina Faso.

Objectives:
The program sought to expand quality abortion care and strengthen enabling environments through integrated service delivery and advocacy. Interventions included provider training, facility quality audits, diversification of abortion care pathways (facility-based, self-managed, telemedicine, and at-home care), and values clarification and advocacy with policymakers, professional associations, and civil society. Routine service data and monitoring reports informed analysis.

Results:
Across the three countries, the program delivered 142,292 abortion-related services to 33,238 clients and trained 134 providers. Eighty-three percent of supported facilities achieved satisfactory or higher quality of care scores. Innovative self-care and digital models expanded reach, particularly to young people and women in remote areas.
Policy and advocacy gains were equally significant. In Togo, political commitment led to a draft decree implementing the reproductive health law and a vade-mecum to protect providers. In Cameroon, a parliamentary task force advanced domestication of the Maputo Protocol, while Niger mobilized coalitions to influence legal reform. These efforts were reinforced by regional collaboration with *Organisation du Dialogue pour l'Avortement Securise* (ODAS), FIGO, IPAS, and IPPF, fostering harmonized advocacy and resource mobilization.

Conclusion:
Collectively, these achievements illustrate that abortion care is no longer confined to clinical structures. It is adapted to the realities of women, young, vulnerable, or geographically isolated, while embedding autonomy, equity, and dignity at the core. The SCAAO experience demonstrates that combining service innovation, quality improvement, legal reform, and regional collaboration can dismantle barriers and build sustainable, person-centered ecosystems of abortion care in restrictive contexts.

P 116

When care cannot wait: abortion access in Iraq

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Background:
In Iraq, abortion is highly restricted, heavily stigmatized, and often inaccessible through formal healthcare systems. Women and girls seeking abortion face legal risks, social exclusion, violence, and severe shortages of willing providers and medications. These barriers disproportionately affect underserved populations, including adolescents, survivors of sexual violence, refugees, internally displaced persons (IDPs), and women experiencing domestic violence.

Objectives:
This abstract examines how a confidential community-based hotline created access to safe abortion care in Iraq, where legal restrictions and stigma severely limit formal service provision, and explores its role as a harm-reduction model for underserved populations.

Methods:
A confidential abortion hotline was established in June 2022 to provide counselling, eligibility assessment, access to medical abortion medication, follow-up care, and referral support across Iraq. Trained healthcare workers offered consultations in multiple local languages and dialects. Clients accessed the service through community networks, peer referrals, healthcare providers, and humanitarian actors. Service records from June 2022 to June 2026 were retrospectively reviewed.

Results:
Between June 2022 and June 2026, the hotline supported 1,432 women and girls across Iraq, including patients from refugee and displacement settings. The age ranged from adolescents under 18 years to women up to 45 years of age, with most aged 25-35 years. Reasons for seeking abortion included unintended pregnancy, sexual violence, domestic abuse, financial hardship, and health concerns. Forty-one clients required referral for additional medical management, primarily due to incomplete abortion, heavy bleeding, or further clinical assessment.

Conclusions:
This experience demonstrates that even in criminalized and highly restrictive environments, community-based confidential models can provide safe abortion access with dignity, continuity of care, and harm reduction, offering a critical pathway for underserved populations.

P 117

Female community health volunteers as frontline agents of safe abortion advocacy in rural Nepal: from policy to community action

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Background:
Despite Nepal's progressive legal framework on safe abortion, established in 2002 and the Safe Motherhood and Reproductive Health Rights Act 2018, significant gaps persist between national policy and local practice. In Konjyosom Rural Municipality, Lalitpur District, unsafe abortions remain prevalent, service utilization is extremely low, and community awareness is limited by deep-rooted stigma and misinformation. Female Community Health Volunteers (FCHVs) represent a critical but underutilized resource in addressing these gaps as trusted frontline health actors.

Objectives:
This project aimed to promote informed, safe, and equitable access to safe abortion services in Konjyosom Rural Municipality through FCHV capacity-building, community sensitization, evidence generation, and local government advocacy.

Methods:
A community-driven, rights-based intervention was implemented over six months, Thirty-eight FCHVs across all five wards received a Values Clarification and Attitude Transformation (VCAT)-integrated safe abortion orientation. FCHVs subsequently facilitated sensitization sessions with local Mothers' Groups (Ama Samuha). Primary evidence was generated through four Key Informant Interviews (KIIs) and one Focus Group Discussion (FGD) with women of reproductive age of the rural municipality, informing a situation analysis document formally submitted to the municipality. A digital social media campaign targeting youth ran concurrently.

Results:
FCHVs demonstrated a 33.77% improvement in knowledge following orientation. Thirty-five FCHVs reached over 474 women through Mothers' Group sensitization sessions. The situation analysis was formally received by the Municipality Chairperson, who publicly committed to continued safe abortion programming. The digital campaign reached 16,513 people and generated 1,900 interactions, significantly exceeding the target of 5,000.
Conclusions
Community-based advocacy anchored in FCHV capacity-building can meaningfully shift knowledge, attitudes, and institutional commitment on safe abortion in rural, stigma-affected contexts. Sustained investment in frontline health workers is essential to translate reproductive rights law into lived reality.

P 118

Description of the clinical pathway of patients receiving induced abortion without routine pre-abortion ultrasonography

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Background:
Mandatory pre-abortion routines have been questioned in recent years. This includes using screening tools evaluating the need for an ultrasonography to determine the site or gestational length of a pregnancy prior to induced abortion.

Objectives:
This is a detailed presentation of the pre-abortion screening tool used at the Helsinki University hospital and the subsequent clinical pathway of patients passing the screening without requiring ultrasonography. The screening tool combines the interview-based no-test model developed by the RCOG with patient characteristics, with the aim of reassuring a safe abortion.

Methods:
All patients were screened using a standardized triage flowchart to assess the need for pre-abortion ultrasound examination. The algorithm assessed menstrual history, pregnancy dating reliability, recent hormonal contraception or breastfeeding, and ectopic pregnancy risk factors. Ultrasound was arranged only for patients meeting predefined criteria.

Results:
A total of 740 women were deemed eligible for no-test abortion based on the RCOG decision aid, supplemented by our local screening criteria, following a structured telephone interview and a subsequent in-person nurse assessment. Between February 24 and December 31, 2025, these patients underwent no-test abortion care without routine invasive investigations. The patient selection process proved to be safe and effective. Data from 2026 will be presented at the conference.

Conclusions:
Our findings suggest that the RCOG decision aid, when complemented with additional local screening criteria, provides a safe and effective approach for selecting patients for no-test abortion, with excellent clinical outcomes.

P 119

Navigating restrictions, reducing risks: implementing the abortion harm reduction model across restrictive settings

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Background:
Unsafe abortion remains a leading cause of preventable maternal morbidity and mortality, particularly in legally restrictive and highly stigmatized settings. The abortion harm reduction model is a practical, evidence-based, rights-centred public health approach that recognises people will seek abortions even when safe services are restricted. It reduces health risks by providing pre-abortion information on pregnancy options, safer self-care, warning signs, and where to seek help, alongside timely post-abortion assessment, care, and referral. The model promotes informed decision-making, autonomy, and prevention of avoidable harm.

Objectives:
To examine how IPPF Member Associations have implemented the abortion harm reduction model in restrictive settings, highlighting key strategies, implementation lessons, and opportunities to strengthen safer self-care and person-centred abortion care.

Methods:
Drawing on IPPF guidance and programme experience, this abstract presents harm reduction interventions delivered through facility, community, outreach, digital, and telemedicine platforms. Case examples from Africa and South America illustrate adaptation to diverse legal and sociocultural contexts.

Results:
The model proved feasible across diverse settings. Since 2016, Member Associations have delivered over 2.3 million harm reduction services by expanding access to accurate abortion information, strengthening informed self-care, increasing awareness of danger signs, and improving referral pathways for post-abortion care. Community approaches—including hotlines, peer educators, pharmacists, and digital platforms—reduced information barriers and reached underserved populations. Provider training, including Values Clarification and Action Transformation (VCAT), strengthened respectful, non-judgmental care, while partnerships supported implementation in complex legal environments. Key lessons included the importance of community trust, multiple service delivery channels, and context-specific adaptation.

Conclusions:
The abortion harm reduction model is an effective public health strategy for reducing abortion-related harm where safe abortion remains restricted. IPPF's experience demonstrates its adaptability across diverse contexts, offering practical lessons for healthcare providers, policymakers, and civil society organisations to reduce preventable morbidity and strengthen person-centred abortion care.

P 120

Strengthening post abortion care services provision through multi-prolonged health system strengthening model in resource limited settings – Namayingo district in Uganda.

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Background:
Unsafe abortion remains a significant health burden in Uganda with prevalence of 15% and 314,300 induced abortions annually. Namayingo district has a high teenage pregnancy rate of 27% and majority culminate into unsafe abortions attributed to restrictive legal environment. Prior to the Standup project implemented by Reproductive Health Uganda (RHU), health facilities were not equipped with MVA kits, misoprostol supplied for labour induction, health workers lacked desired competence and negative attitude towards PAC services hence frequent client referrals.

Objectives:
The intervention aimed to enhance health systems strengthening on provision of PAC services focusing on improving healthcare worker competence; equipment, and commodity supply; strengthening district ownership and accountability for PAC service delivery.

Methods:
Four public facilities supported (Bukatuube, Bugana, Busaala, Muggi HCIIIs) were supported. Three health workers trained per facility, then enrolled into structured clinical mentorship. Quality assurance and data quality assessments with actionable improvement strategies developed. Multisectoral district performance review meetings for evidence-based advocacy and planning. District committed budget allocation for procurement of MVA kits, and supply of COMBIPACK.

Results:
100% (12 health workers) demonstrated improved competence and positive attitude towards PAC services provision. The district procured, equipped each facility with two MVA kits and supplied COMBIPACK. The facilities reported 109 (74 MVA, 35 PAC) in Jan to June 2025. This improved by 12% (133 clients 81MVA, 52 medical) in July to December 2025 and 15% improvement in Jan to June 2026 with 153 clients (138 MVA and 15 medical). Referrals reduced by 80% from 70 referrals in June - December 2024 to 14 referrals between Jan 2025 to June 2026.

Conclusions:
A combined approach of Health worker training, clinical mentorship, evidence-based advocacy, and district led resource allocation can substantially strengthen PAC management. This demonstrates a practical and sustainable model for expanding PAC and contraception services in resource limited settings.

P 121

Battling unsafe abortions in Francophone West and Central Africa: challenges and successes.

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Background:
While safe abortion methods are gaining ground in West and Central Africa, many unsafe abortion methods are still being used, resulting in high rates of abortion complications and maternal mortality.

Objectives:
The aim of this presentation is to provide an overview of the key positive developments and remaining barriers concerning safe abortion in Francophone West and Central Africa.
Methods: The analysis is based on 3 recently concluded in-depth studies in the region, literature review and personal participation by the authors in programmes and spaces that aim to address unsafe abortion.

Results:
The findings show that the region has experienced a series of successes, which are gradually improving access to safe abortion. This includes both major and minor legal reforms, the inclusion of safe abortion methods on essential medicines lists, the grassroots referral and distribution of safe methods, helplines and online support, and the courageous advocacy of civil society organisations and feminist activists.
Despite important progress, various barriers and challenges persist: the very slow domestication of the Maputo Protocol in many countries, religious and cultural opposition to legal reform, limited legal literacy, abortion stigma, the offer of 'neo- traditional' methods, increasingly via social media, and the offer of informal and mostly unsafe abortion services as a business model in legally restrictive environments. All these challenges are compounded by the intensifying attacks of the anti-rights and anti-gender movement on hard-won sexual and reproductive rights across the continent, and beyond.

Conclusion:
Although there has been an increase in access to safe abortion methods, these are predominantly accessible to women with financial means, internet access, social connections and decision-making power. For many, however, access to safe abortion is still hindered by gender digital divide, lack of (financial) autonomy, lack of access to information, restrictive legal frameworks, abortion stigma and conscientious objection.